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ABSTRACT

Since 1992, Vermont has been pioneering the development of community partnerships for improving social well-being, using indicators to track success. The working definition of a community, for outcome purposes, is the area served by a school supervisory union. Vermont is divided into 60 such supervisory unions (school districts), but "community" can be defined in other ways as suits the needs of the people involved. With assistance from several national organizations, new outcomes-based partnerships have been developed, usually organized around changing specific outcomes. Some of the partnerships are collaboratives attempting to set up a continuum of services around the outcomes, and others are more highly structured, with staffing to pull things together. This report supplies background on the partnership initiatives, explains how the partnerships work, and outlines the state's progress using results-based accountability developed by the partnerships. A case study illustrates a partnership in action. An afterword by Mark Friedman gives a broader context to the results-based accountability and community partnership movement in the United States. Appendixes discuss outcome indicators in Vermont and describe the partnership operating in the town of Barre. (Contains 21 graphs and 3 tables.) (SLD)

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Vermont Communities Count

Using Results to Strengthen Services for Families and Children

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September 1999

Vermont Communities Count

Using Results to Strengthen Services for Families and Children

By Cornelius D. Hogan, Secretary
Vermont Agency of Human Services

September 1999

Preface

In the early 1990s, Vermont's Agency of Human Services and Department of Education began working together to more effectively deliver services. An important component of this work was a process of devolving decision-making from the state government to local settings through community partnerships. To track the effectiveness of these efforts, Vermont and its communities began using indicators of well-being to track outcomes (also known as results-based accountability).

The Annie E. Casey Foundation began working with Vermont on its community partnership initiative in 1996. The goal was to help Vermont improve outcomes for children, families and individuals within a system that brings together family, community and state to more effectively deliver social services.

Since then, Casey has supported Vermont's partnership initiative in a variety of ways, including developing pilot partnership programs, funding full- or part-time coordinators for community partnerships, and providing training and technical assistance. Such assistance has come from Casey Foundation staff, the Center for the Study of Social Policy, the Fiscal Policy Studies Institute, Sherbrooke Consulting and Casey Family Services.

Vermont's community partnerships have flourished, and many indicators of well-being have considerably improved. This report supplies background on Vermont's partnership initiative, explains how these community partnerships work and outlines the state's progress on using results-based accountability. Mark Friedman of the Fiscal Policy Studies Institute has written an Afterword (see page 49) that gives a broader context to the results-based accountability and community partnership movement in the United States.

To learn more about the Annie E. Casey Foundation's work in this area, please contact Donna Stark, 410 547-6600.

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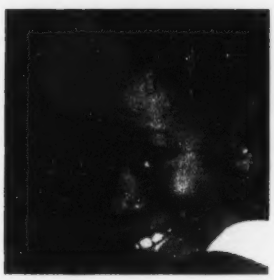
Author's Acknowledgments

A fundamental change is occurring in this nation, as authority and responsibility steadily devolve from the federal government to the states. This change has unlocked great shifts in the relationships among local communities and regional and state governments. At the same time, and not independently, an "outcomes-based" movement has been gathering momentum as states and communities strive to measure progress in, and accountability for, the well-being of their citizens.

So far, there has been little documentation of these changes, simply because the work is so young; the key players have had little time to detail this work in an organized way. This report attempts to address this lack by describing successful community partnerships and the use of indicators to measure well-being in Vermont. It outlines lessons we have learned and offers some thinking for the future.



We are indebted to the support of the Annie E. Casey Foundation, which allowed Vermont to develop its community partnership initiative. This report draws heavily on a variety of publications, interviews and other materials produced in Vermont since 1993 as a result of this initiative.

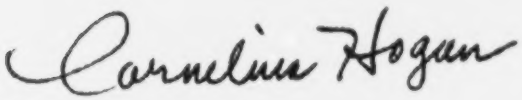
David Murphey, David Baker, Ted Mable and key members of the Agency Planning Division made important contributions to the report's substance and style. Interviews with Carolyn Roberts, CEO of Copley Health Systems; Scott Johnson, executive director of the Lamoille Valley People in Partnership; and William Alexander, executive director of the Lamoille Mental Health Agency, yielded rich substance and insight into the dynamics in Lamoille County.

Cheryl Mitchell, deputy secretary of the Vermont Agency of Human Services (and an important part of the "soul" of this work), provided the "What's Next for Vermont?" view that starts on page 28. William Page has been an important mentor over the years.

Frank Farrow of the Center for the Study of Social Policy, Mark Friedman of the Fiscal Policy Studies Institute and Jolie Bain Pillsbury of Sherbrooke Consulting have provided long-term and steadfast support for the effort.

Tom Moore, Scott Johnson, William Alexander, Susan Hasazi, Bill Page and Carolyn Roberts also reviewed drafts of this report and offered much-needed constructive criticism. Michele DellaSanta and Russell Smith were indispensable in producing this document.

Finally, I wish to acknowledge our policy executives, employees and community partners. Their work forms the foundation upon which we can build better lives for the people we serve.



Cornelius D. Hogan
Secretary
Vermont Agency of Human Services

Introduction

Overview

A new model is emerging for improving social well-being. It is based on the premise that organizing at the community level around broad outcomes — or goals — and more specific indicators of social well-being will result in improved quality of life for local people. Inherent to this new model is the understanding that traditional approaches for improving social conditions — in which federal and state governments impose structure and process — often are not effective at the community level, and that communities and regions are playing much larger roles in this arena. Since 1992, Vermont has been pioneering the development of community partnerships to effectively carry out these increased responsibilities, using indicators to track success.

I must point out that Vermont is a very rural and homogeneous society. I make this observation not as a reason we have been able to succeed, but to highlight that in some places, other issues — including race relations, urban poverty and problems associated with scale — can become major factors. In addition, because Vermont is so small, readers should note that local data often represent very small numbers. It is probably most useful to liken Vermont to a county and consider the information in this report in that light.

Vermont Basics

Vermont is small and rural; in fact, it is rated the most rural state in the country.[1] Among the 50 states, Vermont ranks 43rd in geographic area (9,615 square miles) and 49th in population with 589,000 people. It is essentially a collection of rural communities, with nine cities, 236 towns and 60 villages. Approximately 77 percent of Vermonters live in rural areas. It ranks 35th in average annual pay and 50th in state and local government revenue.[2] Its population is relatively homogeneous.

Vermont's economy depends greatly on small, entrepreneurial businesses. In terms of average annual employment, excluding the state government, 42 percent of Vermont's workers are employed in service industries, and an additional 28 percent are employed in the retail trade, for a total of 70 percent of the population. Of

Vermont's 18,000 full-time business firms, 97.5 percent are small businesses.[3]

Vermonters are environmentally conscious, and they are proud of the state's achievements in this area. Vermont was the second state to enact a bottle law in the mid-1970s, and it is the only state in the country that has no billboards — and hasn't had them for more than 25 years.

Vermont has no regional or county governance to speak of; direct relationships exist between the state government and towns, communities and cities. The state constitution gives insight into the nature of these relationships:

> That all power being originally inherent in and consequently derived from the people, therefore, all officers of government, whether legislative or executive, are their trustees and servants; and at all times, in a legal way, accountable to them.
>
> Chapter 1, Article 6

Article 7 continues:

> The government is, or ought to be, instituted for the common benefit, protection, and security of the people, nation, or community, and not for the particular emolument or advantage of any single man, family, or set of men, who are a part only of that community; and that the community hath an indubitable, unalienable, and indefensible right, to reform or alter government, in such manner as shall be, by that community, judged most conducive to the public weal.

"To be effective, a government must recognize that young people are our future, our single most important asset. In Vermont, our unwavering focus on children and families has helped us make remarkable strides in improving the quality of life for all of our citizens. We have accomplished this through a dedication to measurable results and outstanding leadership and cooperation from state and community partners. I urge leaders in every state to take up this kind of work. Nothing less than our future is at stake."

— *Gov. Howard Dean*

These words make a powerful case for constructing much of the state government's work around improving the well-being of the people, in the most local settings possible.

Vermont has a strong record of investment in services for its people, and these investments have paid off in quality-of-life results that rank relatively high in the United States. (Appendix A on page 52 presents comparisons of Vermont and U.S. indicators.) The state's experience in developing community partnerships based on outcomes-driven work demonstrates just how much Vermont has been able to achieve in education, employment and human services.

Vermont's success in these areas owes much to the governor, Howard Dean, who came into office suddenly in August 1991, when then-Governor Richard Snelling died. Dean, a physician, acceded from the office of lieutenant governor. Early in his tenure, Gov. Dean made improving the well-being of children one of his highest priorities. In 1993, during his one-year tenure as chairman of the National Governors Association, children's issues were his primary theme. In the years since, Gov. Dean has consistently constructed a politically supportive environment and has personally demanded progress in improving the well-being of Vermont's children.

Community Partnerships

Vermont's working definition of community, for outcome purposes, is the area served by a school supervisory union. This school district unit is meaningful to children and families, small enough to be considered truly "local" and usually large enough to provide meaningful data.

Vermont is divided into 60 different school supervisory unions. Most of these represent natural catchment areas of neighborhoods, town or regions. However, in the partnership model, community data, structure and organization can be defined in several ways — they can reflect a single school district, a collection of school districts, a medical or hospital catchment area or a natural economic catchment area. The idea behind this approach is to have local communities with shared interests define the breadth and scope of their communities — and their partnerships — themselves.

The state's responsibility is to aggregate information, structure and organization in ways that can help serve this natural interest.

Reclaiming the roles of communities

There is an increasingly well-articulated view that healthy communities and families should be at the core of a government's work. Social and governmental trends that have eroded reciprocity in the relationships between people and governments have given rise to this conviction.

In truly reciprocal relationships, each participant benefits. That is the nature of a good business partnership — as well as partnerships among entities in a community and, in turn, among those entities and their regional, state and federal governments.

Several trends have undermined these relationships in the United States. First, for the past 60 years, federal and state dollars have been consolidated into categorical funding streams, moving communities and families further away from important decision-making.

In addition, increasingly mobile populations, the proliferation of personal technology, and highway systems designed to bypass communities all have contributed to a reduced role for communities and the families that live in them.

Over the past few decades, these changes have systematically eroded fundamental reciprocity among our communities, counties and regions, states and the federal government. The result: serious imbalances and breaches in relationships and authority.

Although the problem is well beyond what any one state human services agency can handle, agencies and communities can work together to help begin the process of reconstructing badly needed reciprocal relationships.

One of the most important ways governments can encourage this process is to put in place a system in which service agencies negotiate ways of working together and achieving agreed-upon outcomes with the communities they serve. In practice, this means a flatter governance structure — community organizations and service agencies work together to reach common goals.

Community partnerships in Vermont

In early 1991, I was approached by then-Commissioner of Education Richard Mills (currently commissioner of education in New York state). I had only recently been appointed secretary of the Vermont Agency of Human Services (AHS) by newly elected Gov. Richard Snelling. Our conversation was straightforward: Mills believed that if he and I worked together, our agencies could do a better job for Vermont's people.

That was the impetus for giving state and local education bodies, human service agencies and related nonprofit organizations the chance to develop more integrated ways of helping people. In the process, the focus would shift from the state level to the community level.

> "When Con and Rick made their presentation at the Headmasters' yearly meeting a couple of years ago, it was a very 'from the heart' presentation. It was a really courageous thing, because they said, 'We don't know where this is going to end up, but what we do know is that the Agency of Human Services and the Education Department need to work together.'"
>
> — *Elementary school principal*[4]

Other partners in the development of the community collaboratives and partnership movement in Vermont included the Annie E. Casey Foundation, the Center for the Study of Social Policy, the Snelling Institute, the Carnegie Foundation, the Danforth Foundation and the Vermont Community Foundation. Each of these organizations, either in the form of some modest assistance to a community or considerable technical assistance, has contributed greatly to the development of these new outcomes-based partnerships.

One of the early expressions of the partnership initiative was the creation of "Success by Six." Success by Six is less a program than an environment within which people from all disciplines pull together to help achieve one of Vermont's stated outcomes: "Children are ready for school." (For more information about outcomes, turn to page 11.)

Vermont's 10 Outcomes

- Families, youth and individuals are engaged in and contribute to their communities' decisions and activities.
- Pregnant women and newborns thrive.
- Infants and children thrive.
- Children are ready for school.
- Children succeed in school.
- Children live in stable, supported families.
- Youth choose healthy behaviors.
- Youth make a successful transition to adulthood.
- Elders and people with disabilities live with dignity and independence in settings they prefer.
- Families and individuals live in safe and supportive communities.

Several hallmarks of Success by Six include the development of a universal early baby visit program and several expansions of health care for Vermont's children. As of February 1998, 95 percent of our children have access to health insurance.[5]

During the past seven years, the accomplishments of the Success by Six program have spurred successive incremental legislative appropriations to encourage and reward the development of local partnerships and collaboratives around common outcomes. Around the state, communities have developed local collaboratives, each of which has played a role in improving specific outcomes for Vermont's people.

Several of the local collaboratives have improved outcomes to the point where they are ready to begin developing more formal governance mechanisms with the help of AHS and the Department of Education. This will include developing a system of accountability.

Partnerships follow different models

Each of the partnerships is different from the others. In many cases, the partnerships are organized around changing specific outcomes, such as in the City of Barre, where the fundamental objective is to reduce teen pregnancies, child abuse and other indicators, using lifelong literacy and learning as a vehicle (see Appendix B, page 62).

Some of the partnerships are collaboratives of service providers attempting to set up a continuum of services around the outcomes. Other partnerships are highly structured and have staffing to pull things together. Lamoille Valley fits into that category (see the Lamoille Valley case study on page 31). A partnership in the southeast region of the state has gained private nonprofit [(501(c)3)] status, with the United Way playing a key role. The largest partnership is an organization called the Champlain Initiative in Chittenden County; it includes approximately 25 percent of the state's population and involves more than 300 organizations.[6]

Vermont's Community Partnerships Map

Franklin/Grand Isle Community Partnership
Orleans-Northern Essex Regional Governance Board
People in Partnership (Lamoille)
Champlain Initiative (Chittenden)
Caledonia Coordinating Council
Washington Area Family Services Collaborating Council
People for Addison County Together
The Barre Project
Rutland Regional Board for Family Services
Community Partnership of Orange/Windsor
The River Connection (Springfield)
Alliance for Building Community (Brattleboro)
Catamount Partnership for Community Health

Source:
FY99 Budget & Program Overview and Recommendations for the Agency of Human Services

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Communities learn from one another

People who have backgrounds in child and family development often address community development issues in similar ways. Research shows the critical interaction between basic heredity and the environment. Similarly, community development work is an unfolding of new capacities within the original set of resources. As communities come to understand their strengths and put these strengths to new uses through Vermont's partnership initiative, we've seen new skills for problem solving emerge, new support systems set up, improved communication and improved momentum toward the outcomes.

And just as children frequently learn from watching one another and modeling adults in their lives, Vermont's community partnerships have learned from each other. People in Partnership watched as People for Addison County Together (PACT) worked on a single application for client services. PACT watched as the Alliance for Building Communities (ABC) developed an assessment process. ABC watched as People in Partnership began negotiating reinvestment agreements — and so on around the state.

Development is not a straight-line process. Frequently, there are fits and starts, and once a community gains an area of competence, it may take the back seat as the community focuses on a new area. Persistence is key.

Vermont benefits from stronger communities

An important rationale for increased roles for communities and families is economic. Early intervention, using community partnerships to do more of the work, results in improved fiscal flow over time, in addition to improving the well-being of people.

Vermont — as often as possible through its community partnerships — has made significant investments in early intervention and prevention activities. Those investments have resulted in improved outcomes and lower costs, and have opened opportunities for further prevention investments.

For example, in the context of a strong economy, investment in our welfare program has resulted in lower costs and more people going to work. In just four years, the Assistance to Needy

Families with Children (ANFC) budget has been reduced 25 percent, from $60 million to $45 million. Since the 1994 fiscal year, the monthly earnings of working ANFC households has risen 44 percent.

Although uncollected child support totals $70 million (1.5 times the entire welfare budget), collections are up over 300 percent since 1991, an average gain of 43 percent per year. The result is more than $100 million in additional support for families with children, many of whom are struggling economically. For some, the additional income will get them off the welfare rolls; for others it will help them remain self-sufficient.

Prevention work in teen pregnancy also has paid off. The estimated public costs (ANFC, food stamps, Medicaid, etc.) associated with a single teen pregnancy are almost $20,000 a year. Teen pregnancies in the vulnerable 15–17 age group are down 36 percent over the last eight years. That's 367 fewer pregnancies over that period than the 1989 level would predict. This translates into an avoided demand for services of $7 million over the eight-year period.

Prevention investments are paying human and financial dividends for young children as well. Each year, some 25 percent of Vermont's kindergartners (about 1,600 children) are judged by their teachers as not ready to begin school. We estimate that about 5 percent of these children have received such poor starts in life that they are at high risk of becoming future clients of Vermont's Social and Rehabilitative Services (SRS) or Corrections Department.

One marker of our successes in this area is the recent decline in child abuse and neglect victims aged five and under. There were 33 percent fewer abused children in this age group in 1996 than in 1990 (a total over the period of 546 children). This translates to more than $16 million in avoided costs (residential care, health care, mental health services, etc.)

Overall numbers of child abuse and neglect victims declined 29 percent between 1990 and 1996 (1,467 fewer children). Since we estimate the annual costs (residential care, health care, mental health services, etc.) associated with each victim at over $30,000, that works out to a total of more than $31 million in avoided costs.

Community prevention efforts also have benefited Vermont's elderly. Through our Medicaid waiver, we've shifted 400 of our nursing home beds, with average annual Medicaid costs of $36,000 per bed, to home- and community-based care settings, where the average cost is $26,000 per bed. Over the past five years, we've avoided more than $15 million in expenditures that would otherwise have gone into new nursing home beds.

These activities and others have resulted in lower relative costs in some very important areas.

Vermont's per capita cost-ranking across states

- Medicaid (elderly) — 29th lowest
- Public health — 36th
- Psychiatric hospitals — 38th
- Police — 42nd
- Medicare — 43rd
- Corrections — 47th
- Hospitals — 47th

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Outcomes Are Everything

What Are Outcomes?

An outcome is a desired state or an improvement in the condition of children and their families, broad enough to extend beyond any single organizational entity or hierarchical level. It's an outcome if you can measure its indicators.[7] In addition, outcomes must evolve so that:

- local people help create them;
- they ring true (in other words, they make sense); and
- they impel people to act.

Simply put, an outcome is a result that is adopted by people across many disciplines and organizations. In essence, a well-constructed outcome, as measured by specific indicators, is large enough to make a difference, but small enough to be strategically managed.

The ability to disaggregate the information at the local level is a key process in the outcomes way of doing business.

What Are Indicators, and Why Are They Important?

In a business environment, an enterprise that has no indicators to adequately describe its direction — in terms of sales, cash flow, target markets, etc. — probably will not succeed. The same is true of government. Tracking indicators and outcomes should be at the center of all of our work — yet it is one of the things that government at all levels has not done well.

In theory, we ought to be able to have the same kind of detailed, up-to-the-minute, accurate data on the well-being of our people as we have about our sports teams or the stock market.

Indicators are the tools with which we take our bearings, chart and correct our course, and monitor conditions around us on an ongoing basis. Indeed, sometimes these are the only reasonably reliable instruments to help us see our way through the ever-shifting conditions of public policy, economic and social trends, advocacy, and political rhetoric.

Often, deciding how to quantify social well-being gives rise to major logistical and conceptual issues. We do see a consensus emerging, however, around measures in certain fundamental areas:

- poverty
- child welfare
- public health
- education
- safety

The social well-being indicators Vermont uses are certainly not perfect. In fact, they are sometimes crudely conceived, slow to be reported and often maddeningly imprecise. We hope to develop better indicators, particularly ones that focus more on positive conditions of well-being, rather than on negative ones. Nevertheless, we depend upon the indicators we're using now to give us the best possible reading of where we are and where we're headed.

Vermont is not alone. Throughout the United States, state and local governments are beginning to refocus their efforts around results or outcomes, and this is reflected in a stronger recognition of the critical importance of social indicators around the country.[8]

Following are some of the fundamental reasons using indicators and outcomes to guide our work is essential. They are adapted from a talk I gave to members of the Association for the Treatment of Sexual Abuse in 1997.[9]

Indicators tell you where you've been, where you are and can guide you to where you want to go. It's such a simple concept that we often forget how to apply this kind of thinking. Taking stock is a normal and important part of the human enterprise, whether it is family, work or community. Knowing the answer to the question "Are we getting better or worse over time?" is the ultimate accountability. I remember one of the speeches Ronald Reagan made during the election campaign against President Carter, when he asked the basic question, "Are we better off or worse off today than we were four years ago?" The public response to that basic question was astounding, and in many ways shows the power of indicators.

Indicators can help us understand how we are doing compared to others. Government agencies and organizations are famous for creating incomparable data. Vermont tries to use data that can be compared, not only to other states and to the nation, but in certain cases to international data. For example, recently we have been seeing a substantial decline in teen birth rates in Vermont. I can show that same data for the nation, which seems to demonstrate that we finally are moving in a positive direction.[10] However, it is an important, sobering and humbling fact that teen pregnancy rates in Vermont are still seven times that of Switzerland.[11] The ability to compare is very important.

Over time, indicators give you the basis for cost-benefit analysis. In Vermont, we have been making the proposition to the business community, the governor's economic advisors and others who understand the concept of investment and apply it daily in their own work, that by tracking indicators over time, we can make some solid assumptions about cost structure. The story is particularly good when indicators are going in the right direction.

For example, a reduction in child abuse during the past five years has resulted in millions of dollars in decreased demand on the child welfare system. For every avoided case of substantiated child abuse we realize a savings of $31,000. Between 1991 and 1995, these avoided costs totaled $32 million.[12] This gives Vermont's communities an opportunity to put more funding into thoughtful child- and family-friendly investments.

Indicators can present great motivation for community self-improvement. In 1992, I addressed a Rotary Club in the community of Bennington. Usually these talks are 20-minute speeches in which you make two points, you have immediate feedback and they are over and done.

However, this particular day I showed two charts. The first chart was the good news chart. I showed the audience the early stages of a strong downward curve in child abuse in Vermont. A couple of people in the audience spontaneously applauded, and I was a little taken aback. I guess I hadn't thought through how fundamental this issue is to many people.

Then I brought out the bad news chart.

The chart showed that even though Vermont's statewide news is good, the same couldn't be said for Bennington. Statewide child

abuse rates were going down but Bennington's were going up. Within a minute, I had this audience of normally calm business people very upset. They demanded to know why it was happening in their community, where it was better, why it was improving in other areas and what they could do about the situation. I am pleased to report that since then, child abuse rates in Bennington have declined significantly, almost to the level of the state's improving rate.

Indicators become interactive and help build critical mass for change. There was an interesting article in *The New Yorker* a couple of years ago called "The Tipping Point."[13] The authors examined the dynamics of crime in New York City and applied an epidemiological view to social science. In essence, the article explained that the interaction of various disparate factors can quickly add to a "tipping point," in the dynamics of the spread of a disease; i.e., whether it is contained or spreads and becomes an epidemic.

In Vermont, after seeing some of our input indicators — which reflect early intervention or prevention strategies — improve over the last few years, we've seen a corresponding change in outputs. For example, along with growth in the percent of population covered by health insurance, the number of women who have early prenatal care and the percent of newborns receiving home visits, we've seen teen pregnancy rates and child abuse decline and numbers of children who need special education moderate.

The message here is that the indicators can affect each other, and when you can make progress in a few, others will follow, resulting in a "tipping point" for certain social trends. The child abuse reductions that we are experiencing, along with the teen pregnancy reductions and others, are beginning to pull along other indicators of well-being.

Indicators make the public more confident that we in government know what we are doing. This is very important, particularly in this era of public dissatisfaction with and distrust of things governmental. Indicators are a common-sense, proactive way to help raise public consciousness about the work we are doing.

In essence, outcomes and indicators convey critical and complex information in a way that is easy for most people to readily understand — and act upon. When the public understands what you do, you are much more likely to get their support.

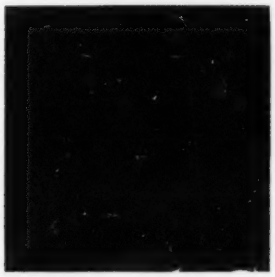
Over time, well-constructed indicators systematically build budgetary and political support. Using indicators washes some of the politics out of budgetary and short-term decision-making. The indicators are what they are, and they tend to promote much more dispassionate and objective debate than the politicized information that often leads to budgetary and political food fights.

In our little state, 1999 is the seventh year that we have produced statewide indicators and the fifth year that we have produced localized indicators. This work already has resulted in a change in our legislature, where the concept of investing in prevention has become more readily accepted.

Indicators move prevention and investment in early intervention forward. One of the reasons AHS focuses on outcomes is because they open the floor to this concept of investing in prevention and early intervention. We realized that if we didn't figure out a way to change the way we invest, we were going to lose more ground and use more money on back-end services.

Indicators connect us more closely to the business community. Government human and social service agencies have not always done a good job of relating to the business community in its own language. But the business community has a lot to do with our success or failure.

The business community understands outcome thinking because it leads to cost-benefit thinking. Cost-benefit thinking in turn leads to investment thinking, and investment thinking results, again, in outcome thinking. It's a logic that business people understand. When human and social service organizations are able to present outcomes in this systematic fashion to Rotary Clubs, Business Roundtables and other business groups, it goes a long way toward creating business understanding and support for investments that pay off in terms of improved social capital.



Well-constructed outcomes cross agency and organizational lines, becoming common targets for all of our work. Outcomes bring common purpose. For example, the outcome "Children are ready for school" embraces the work of virtually all of our organizations, from intergenerational reading programs to health programs for children. Also, the reduction in child abuse rates for children under six years old clearly is a factor (an input) in the number of children who are ready to begin school. These broad outcomes bring together disparate organizations to contribute, in one way or another, to the common outcome.

Using Outcomes and Indicators in Vermont

In 1992–1993, the educational and human service systems set about to find common ground in the way they worked. This process took Richard Mills, the commissioner of education, and myself, as secretary of AHS, on the road to every part of the state. We listened to what our citizens had to say about our early vision of a more integrated and unified system on behalf of children and families. This is our initial vision statement:

- Vermonters are competent, caring, productive and responsible citizens, committed to lifelong learning, who contribute value to their families and communities.
- Families have primary responsibility for their children's physical, mental, social and spiritual development.
- Communities support families by joining with state and local government to create a unified system of education, health and social services that are of high quality and respect the diversity, uniqueness, strengths and potential of individuals, families, schools and communities.
- These services are school- and community-based, easily accessible, family-centered, aimed at promoting self-sufficiency, oriented toward prevention and focused on the safety and well-being of Vermont citizens, especially its children.[14]

At about the same time, both AHS and the Department of Education were obtaining modest General Fund appropriations to grant to local collaboratives. The aim was to begin the process of creating more local focus on and attention to specific outcomes and indicators, such as child abuse and teen pregnancies.

In that formative period, the State Team, a multidisciplinary group of people representing a wide range of interests, was engaged to begin the process of identifying and formalizing a set of agreed-upon outcomes along with measurable indicators related to each of the outcomes.[15] The State Team makes sure the indicators are technically sound, and that we consistently improve and constantly re-examine them.

In Vermont, the AHS, the Department of Education, the legislature and our local partners have identified as common ground a commitment to achieving the following outcomes:[16]

- ❖ Families, youth and individuals are engaged in and contribute to their communities' decisions and activities.
- ❖ Pregnant women and newborns thrive.
- ❖ Infants and children thrive.
- ❖ Children are ready for school.
- ❖ Children succeed in school.
- ❖ Children live in stable, supported families.
- ❖ Youth choose healthy behaviors.
- ❖ Youth make a successful transition to adulthood.
- ❖ Elders and people with disabilities live with dignity and independence in settings they prefer.
- ❖ Families and individuals live in safe and supportive communities.

These outcomes, with their related indicators, are the center of the work of the community collaboratives that have emerged in Vermont since 1993. State funding for community partnerships now is based on the well-being indicators. This helps us target work to improve specific indicators that are sub-par in particular areas of the state.[17]

This work has been supported by successive legislatures. In the current term, the Senate Committees of Appropriations, Health and Welfare, and Education introduced language to make the concept of well-being outcomes and their related indicators a matter of law. The language follows:

> "It is the purpose of the general assembly to support and encourage the collaborative ventures undertaken by The Agency of Human Services, the Department of Education, the University of Vermont and their community partners in order to improve the lifelong well-being of all Vermonters and to create a research partnership with the University of Vermont.
>
> The Secretary of Human Services and the Commissioner of Education shall file with the general assembly a written report regarding the development of state and community partnerships, and the status of state and local outcomes. The report shall be filed annually on February 15.
>
> The outcomes to be reported are: the well-being of pregnant women and newborns; the well-being of infants and children; the readiness of children for school; the success of children in school; children living in stable, supportive families; young people choosing healthy behaviors; successful transition of youths aged 18 to 24 to adulthood; families and individuals living in safe and supportive communities."[18]

Vermont Reports Progress in Several Ways

If the state and communities are to take seriously the challenge of improving the well-being of children and families, there must be an accounting of that well-being. One of our rules of the road as we developed the outcomes was that they had to be measurable by a series of indicators. Although not all our outcomes are completely described and measured by their related indicators, there are enough of them to give at least a sense of the status of the described outcome.[19]

Methods of reporting the outcomes and the indicators, both at the statewide level and the local level, are myriad and limited only by creativity and imagination.

Well-Being Report

Vermont's first effort in this regard was the publishing of our first "well-being report," *The Social Well-being of Vermonters*, in 1993. The report was a compilation of 51 indicators, distributed among the outcomes, that graphically portrayed progress (or lack of progress) over time, and in most cases compared Vermont to the nation. Each of these half-page graphs was accompanied by another half page of discussion and analysis that outlined technical considerations, along with information regarding the potential connection of the indicator to other indicators.[20]

This report was well received by the legislature, the administration and the media. Print articles featured specific outcome pages from the report. The press became interested in the community development work that was emerging around the state.[21]

Community Profiles

In 1995, AHS published a localized version of the well-being report, *Community Profiles*.[22] *Community Profiles* had a format similar to the statewide report, but took well-being comparisons to the level of 60 school districts. These profiles compare school district data to county and statewide indicators.

Vermont's *Community Profiles* Up Close

Our *Community Profiles* reports usually present rates as well as counts for each indicator. Rates (for example, percents, or rates per 1,000 population) adjust for the varying size of populations. Population figures used in calculating rates are estimates, not exact counts; therefore, the rates shown are also estimates. Because numbers (or counts) at a community level (and sometimes even at a county or state level) can be small, even small year-to-year changes can have dramatic effects on rates. In order to provide a more reliable basis, we calculate some community-level numbers and rates using three-year averages. In such cases, data labeled "1995," for example, refers to the average of the years 1993–1995.

In the back of the report we provide detailed notes and statistics on the indicators, including (where appropriate) the actual numerators and denominators used to calculate the rates, and "95 percent confidence ranges." The confidence range, similar to a margin of error, represents the range of values within which the "true" or underlying rate is likely to fall (with no more than a 15 percent rate of change). If the confidence ranges for any two rates for a given indicator (e.g., state and county, county and community) overlap, they are not significantly different, statistically speaking. However, statistical significance is only one factor communities may want to consider as part of their assessment and planning.

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Generally, the most meaningful and useful comparisons for a community are with itself, over time. However, for each indicator, we also present data for the state as a whole and for the relevant county to provide additional context for comparisons. For some indicators, we also identify statewide goals set out in *Healthy Vermonters 2000*, our public health compendium.[23]

This project reflects the cooperation of many people within AHS and elsewhere in state government. Original data sources are noted in the back of the report. However, responsibility for the accuracy of the data rests with AHS's Planning Division.

The format for the *Profiles* is a work in progress. As communities consider and use the data, they tell us how to make it better and more useful. This approach quickly allows any given community or local partnership to understand how well-off its people are, in very specific ways.

Spreading the word

Proactive distribution: We distribute hard copies of both the *Community Profiles* and the statewide well-being report to Vermont's media, editorial boards, community partnerships and other opinion-makers in specific Vermont communities. In addition, every legislator who is on one of the standing or special committees that interact with either AHS or the Department of Education receives both the well-being report and the *Community Profile* that reflects his or her individual county or school district.

Internet: Since 1997, all of these data have been available on the World Wide Web (www.dsw.state.vt.us/ahs) in downloadable form. By reviewing "hits" we know this is a very popular feature.

Wall charts: One of the most effective ways we have found to share the outcomes is a set of large wall charts that show fundamental trends. We post these charts in places where people come together for training and meetings. For example, the AHS building has a large meeting room known as the Skylight Conference Room. The walls of the Skylight Room now are lined with clusters of wall charts that show progress toward outcomes — or the lack thereof. The same technique is used in the local AHS offices of Morrisville in Lamoille County.

Top 10: We generate a special "top 10" list of communities or areas that have shown the most progress in the most indicators. This management report is the basis for customized analysis letters to each of those communities or partnerships.

Television: Once a year, AHS hosts an interactive television program to present the reports. The target audience is government's middle management and representatives from the substantial nonprofit community. (This is important because more than 80 percent of state and federal funding administered by AHS goes directly to benefits for people or grants and contracts to nonprofit and for-profit agencies.)

Prevention Conference: Each year, the reports are summarized at the annual Governor's Prevention Conference, an assembly of several hundred people from across Vermont who are interested and involved in the broad prevention agenda.

Staff evaluations: Starting in 1998, Vermont added a question to the annual personnel and contract evaluation forms for state government employees and contractors: "What did you or your organization do this past year to help improve the well-being of Vermonters, as measured by Vermont's outcomes and indicators?"

Word of mouth: Personal communications between families and local providers — for example, conversations that occur during early baby visits, which now reach 70 percent of all newborns in Vermont, rich or poor — promote higher expectations about the future well-being of children. Between 1993 and 1999, we reached the families of more than 17,000 babies this way.[24]

In these ways, information about outcomes and indicators reaches our citizens, from those at the highest levels of state government to the average person on the street. The result is a broader understanding of and enthusiasm for focusing on outcomes and indicators. It also gives rise to healthy and friendly competition among communities.

Our future plans to enrich the data available to Vermonters includes localizing ANFC data and disaggregating Medicaid system data. We also are exploring the application of GIS mapping technology to more effectively present data to communities.

Using Outcomes to Shape Human Services

The use of outcomes, both nationally and in Vermont, has focused on the well-being of children and families. Most of that work has taken place in the realm of social and human services, including health and education.

Traditionally, we've organized our thinking about human services around line agencies and departments, such as the Department of Social Welfare, the Department of Education, the Department of Mental Health, the Office of Child Support, the Department of Public Health and so on.

Over the years, however, that categorized concept has started to give way to the idea of developing our work around functions that encompass the mandates of several line agencies. For example, early childhood development is a function that cuts across all of the agencies listed above, as well as Corrections.

At one point, as part of the movement toward managed care, longer-term developmental issues regarding health and its connection to other sectors took a back seat to cost control. However, during the past several years, Vermont's AHS and the Vermont Association of Hospitals and Health Systems, with particular leadership from Copley Hospital in Lamoille County, have agreed on a common set of outcomes and indicators.

For example, AHS and the health care system are working together on the outcome "Infants and children thrive." Our modest goal is to have the lowest infant mortality rate in the world. Vermont's infant mortality rate had always been significantly better than the nation's, but during the 1990s, Vermont's rate stayed stable between five and six infant deaths per 1,000 births, while the nation's infant mortality rate dropped from 12 deaths per 1,000 births to about the same level as Vermont's.[25]

Using this common indicator, both the human services system and the health care system recognize that by localizing the indicators, informing communities about their specific infant mortality rates and helping communities make the connection between infant mortality and related indicators such as low birth weight and smoking, we can improve this outcome.

Many agencies, including AHS, use the outcomes and indicators to inform the budget-setting process.

Accountability: Tying It All Together

Accountability has many definitions, and they're often related. For example, there is the straightforward notion of moral accountability, simply doing what is right. Then there is accountability associated with performance — measures of efficiency and productivity within a defined programmatic area. And there are higher-level political or fiscal concepts of accountability.

These sketches largely define traditional systems, categorical fiscal flow and specific and related programs. While they are all important accountabilities, we have been searching for a new way of thinking about how people are best served, and how all players in that process can be held accountable.

Accountability, in the best sense of the word, is the recognition that activity, focus, organization, leadership and resources all can combine to bring about a desired result or outcome, and that all those who contribute can take credit.

Indicators: Entries on Vermont's Balance Sheet

The business analogy for accountability is a balance sheet. The primary outcome for a business is to improve the equity of shareholders. "Improved equity" is a broad outcome that serves as an umbrella for all other business functions, such as treasury, marketing, inventory, sales and workforce development.

The equivalent of "equity" in the people business is the well-being of citizens, using specific indicators that represent progress toward agreed-upon outcomes. For example, the outcome "All children are ready for school" is best achieved when all functions, in and out of government, can demonstrate that they are contributing to achieving this outcome.

In this system, an important part of accountability is presenting to local communities, in a straightforward and understandable way, "balance sheets" regarding social well-being. It's vital to ensure that local people accept data as valid. It's also crucial to promote an environment in which local partnerships can develop strategies and carry them out to improve the outcomes.

Accountability at the Community Level

The real value of prevention and early intervention investments is that these activities raise community expectations and release previously untapped energy. This value-added aspect of the process has yet to be calculated, but it is immense.

In Vermont, for example, we've cut the child sexual abuse rate in the under-six age group almost in half in the past few years.[26] Inexpensive early intervention programs, expanded health care for children and tougher reporting and enforcement all have played a role. But what is uncalculated is the power of citizens spreading public health messages at the grassroots level, in ways state government could not hope to do. An analysis of the child abuse reductions shows that those areas of Vermont with the strongest local collaboratives enjoy the best results.

Using ever-developing community partnerships as key vehicles, the potential to engage communities around an expanding range of outcomes and indicators is vast. This is the basic framework for developing systems of accountability. See Appendix B (page 62) to learn how the City of Barre developed a system of accountability based on local outcomes.

In the End, Accountability Is About Building Support

When we come upon an apparently successful and effective community, do we know why? Who is responsible for that success and effectiveness? Who is accountable? Is it the mayor and the governing council? Or are the school board and the education establishment the ones who are accountable? Perhaps it's the police or fire services. It might be the service clubs or the sports and recreation programs. The list of assets can be formidable,

and the number of people involved are many. Healthy church life, the media, the arts community, and strong economic and family environments all play a role. All these people can take pride as contributors to this healthy community. They are all accountable in the best sense of the word.

One of the unfortunate by-products of traditional hierarchical organizations is that control and accountability are limited to individual programs. Mark Friedman makes the case that accountability for such programs is really based on performance indicators of productivity and efficiency.[27] Even at that level, many data-gathering efforts slip to mere activity indicators. For example, they ask "How many?" instead of "How well?"

Another view of this kind of accountability is understanding the personal sense of achievement and recognition when something in which you are involved goes well — or the sense of concern and worry when things go badly. This is a healthy sense of personal accountability that cuts to the heart of human nature. It is a much more powerful construct than hierarchical or programmatic accountability.

This view requires a broader version of accountability, authority and responsibility than our traditional ways of governing allow. In this sense, accountability is not an exercise in fixing blame, but in building support. In the broader world of outcome thinking, accountability is not focused on a particular organization or structure, or on any given person or people within that structure. It is focused on the best interests of all of the people within a community.

Over time, this way of thinking changes the role that state government can play and enhances the work of communities.

This is an important lesson. The state can help with some of the building blocks that help support a healthy community, such as providing universal health care for children. In addition, the state can help insure basic equities like adequate school funding. However, the real work — the work that makes the difference — is now occurring in Vermont's communities, where people across

this little state are engaging each other and partnering with state government around improving the well-being of their people in measurable ways.

The improvement of an ever-wider range of outcomes and results for our people, community by community, is the truest sense of what accountability is all about. Structure, politics, organizations, programs, activities — all take a back seat to improving the indicators of well-being. This process is the ultimate, most effective view of accountability.

What's Next for Vermont?

A Critical Mass Now Exists

Outcomes-based accountability in Vermont is now well into its seventh year. During that time, we have seen the strong growth of local collaboratives and partnerships with state government. But most important, we have seen indicators moving in a positive direction as they support the broader outcomes.

Critical mass, in the physical world, creates gravity. In Vermont's community development initiative, local collaboratives have gained enough momentum and touched enough lives that they are developing a sort of gravity, or critical mass, of their own — drawing ideas, energy, outcomes, technology, programs and people into the overall prevention and outcome agenda. In turn this creates more energy and more critical mass. All this helps develop a strong system of accountability.

Community Reparative Boards

One of the best examples of community accountability at work in Vermont is the emergence of Reparative Justice Boards, administered through the Department of Corrections. Currently, there are 30 boards composed of lay citizens to whom the courts send nonviolent offenders with a high potential for rehabilitation.

The concept that drives the boards is reciprocity: Offenders come from communities and their actions take something away from communities — so they should help repair communities.

A board typically meets with offenders and explores all aspects of crimes. Victims also are invited to be part of the process. The board, the victim and the offender agree upon the offender's reparation to the community. Under the law, the board may require a direct apology to victims, direct restitution to victims or community service.

This rapidly growing movement in Vermont indicates how much communities yearn to take more control over their futures.

The Next Few Years

We feel Vermont now is ready to develop local governance structures that are flexible enough to work on different outcomes in different parts of the state for different reasons. Vermont and a

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few other states are ahead of the pack in this area. We're experiencing the beginning of a major shift in the way government delivers services to citizens, starting with the devolution of responsibility and authority from federal to state to local systems.

New legislative language gives the commissioner of education and the AHS secretary considerable discretion in determining when a community partnership is eligible for additional resources to begin developing such governance structures. The criteria we will use to make these initial judgments include the inclusiveness of the partners, their strategies to engage local people and the degree to which a partnership's mission is focused on changing specific outcomes and indicators.

Over the next three or four years we will see the regional partnerships continue to gain in strength, capacity and focus. Increasingly, they will be seen as equal partners with state departments to achieve significant ends. We also will move toward a more equitable allocation of resources based on what we've learned about rewarding positive outcomes. We'll see uneven performance around the state as key players in the smaller community partnerships such as Hardwick, Barre City and Bellows Falls come and go. The flywheel of the larger, more regional partnerships will provide an important safety net.

The relationship between AHS, the education department and the health care system will continue to grow. The relationship with the courts is being strengthened, and it is very possible that with a new emphasis on adolescent issues, we'll see new players become part of community partnerships.

As we move forward with this partnership work, we hope to be able to focus more on supporting one another's work rather than devising elaborate systems for tracking accountability of the program or activity. As the sense of mutual accountability grows, the need for detailed reporting structures will diminish. This saved time will be reinvested in professional development and improved communications flow. We'll move toward peer review processes, rather than top-down evaluation approaches. This may mean that within our own agency, our staff will be given the flexibility to adjust their job descriptions to meet changing circumstances and to share their skills more fully with people in other departments, as well as with people in our communities.

We also need high-quality professional development opportunities for teachers, criminal justice personnel and human services providers. We need to enhance each district's and each agency's capacity to provide leadership and training opportunities to nurture and sustain the next generation of leaders to act as coaches, mentors and trainers.

In the short term, one of the next steps will be to continue the systematic review of indicator progress in the partnership areas. We will learn more about the common characteristics of successful partnerships from these assessments.

Changing Roles for States

Most state governments are accustomed to providing services directly, in rather impersonal, uniform ways. The development of community capacity to take on many of these responsibilities and authorities will fundamentally change the way states govern.

In Vermont, the state's role in developing effective, reciprocal partnerships continues to evolve. One of our most important roles is to continue to put in place the strategies that form a solid foundation for community development work. State leadership must maintain a clear vision, providing information, identifying opportunities for change and convening local partners to address those changes.

We consider the completion of the movement toward universal access to health care a primary strategic initiative. Over the next two years, we will achieve statewide access to early baby visits for all newborns. Another state strategy is to enhance early childhood development work, including higher quality child care, infant and toddler services, Head Start-type preschool, greatly increased focus on early literacy and strengthening our essential network of parent-child centers. In addition, Vermont's state government will enlarge its roles in negotiation and monitoring as its direct service work declines. More direct services will occur in communities.

The path won't be smooth. In some places, the process will take many years and will involve considerable trial and error; it will require great patience and understanding. In other places there will be rapid and constant progress. But overall, we will see measurable improvement in the well-being of our people.

CASE STUDY

Lamoille Valley: People in Partnership

Sailing the Uncharted Waters of Change

One of my joys is sailing, with an occasional blue water trip. These trips are not unlike Vermont's journey into the uncharted waters of outcomes, community development, partnerships and accountability. This is where the ingredients of leadership, ability, relationships and trust are directly connected to productive experiences. No other area of Vermont has gotten a better start on its journey than Lamoille County.

During the past few years, almost all of the indicators in Lamoille County have improved at least as much as statewide indicators. In fact, five indicators have performed at higher levels than the state — in some cases, in multiples. Many of these indicators began to show accelerated improvement at the same time that partnerships became a real factor in the way Lamoille County delivered human and educational services.

Other factors have played into the strength of Lamoille's community partnerships. Lamoille was one of the first areas to receive Success by Six resources, which were primarily aimed at getting community partnerships off the ground to improve the well-being of children under six years old. Next, Lamoille is the only region of the state where health systems — mental health, hospitals and long-term care — work in conjunction. Lamoille is also one of only three sites in Vermont where the state and its community partnership, People in Partnership, agreed to work together to reduce the number of children in custody.

Finally, People in Partnership has enjoyed particularly strong local leadership as well as constant support from the governor, two successive commissioners of education (Marc Hull and Richard Mills) and the Vermont Agency of Human Services.

As recently as 15 years ago, the Lamoille Valley Human Services District was known for its fragmented services, lack of cooperation and outright hostility among its service providers and case workers. Today, this same district is known for effective cooperation and collaboration between service providers and community members.[28]

What turned Lamoille around? As usual, no one thing was responsible for the profound changes Lamoille County experienced in the 1990s. Rather, a series of events, some external and some internal, changed the way people in the district worked together. William Alexander, executive director of Lamoille County Mental Health, puts it simply: "Some years ago, and it is hard to determine the exact moment, the leadership in this county began to look at outcomes through the eyes of our clients and other agencies. This basic shift has served to organize and even accelerate our partnership possibilities."[29]

About Lamoille County

Lamoille County is largely rural, with a population of around 21,000 people. It is one of the fastest growing counties in the state. Home to two major ski resorts, Lamoille's employment is concentrated in the service industry and in wholesale and retail trade. There is a small manufacturing sector and some farming. Its 10 towns include areas of isolated rural poverty as well as wealthy resort communities.

Leadership in Lamoille

A common way to assess community strength is to look at the longevity and impact of an area's leaders. Lamoille has had extraordinary, active, experienced community leadership. The accumulated experience of the key Lamoille Valley players totals more than 225 years. Following is a list of some of Lamoille's most active leaders, along with the number of years they've held key positions in the area. None of these leaders is a wallflower; each, in his or her own way, carries a formidable reputation. Their wisdom and experience have given Lamoille an important foundation for developing partnerships.

WILLIAM ALEXANDER, executive director, Lamoille County Mental Health Agency; 16 years

ALICE ANGNEY, school superintendent; 12 years

SARAH BALLOU, pediatrician; 18 years

JERRY JEFFORDS, regional director, Child Protection; 18 years

SCOTT JOHNSON, executive director, People in Partnership; 23 years

JOHN KAEDING, medical director, Copley Hospital Emergency Room; 20 years

ANN MALLETT, executive director, Lamoille Home Health Agency; 18 years

ANN MARTIN, executive director, the Lamoille Family Center; 12 years

FLOYD NEASE, executive director, the Laraway School; 25 years

KAY NESKIE, district director, welfare; 25 years

LINDA NORTH, district director, Department of Health; 10 years

CAROLYN ROBERTS, CEO, Copley Health Systems; 16 years

CAROLYN RUSSELL, former Social and Rehabilitative Services district director; 20 years

OTHO THOMPSON, educator; 10 years

People who work in the Lamoille Valley describe several elements in the mosaic of their collaborative effort. These elements include:

- shared beliefs;
- consciously working toward a broader definition of community;
- persistence and a positive attitude;
- the willingness of individuals to trust one another and to develop new ways of doing business built on that trust;
- a commitment to "doing what's right for families" as the central tenet of the system;

- being willing to take risks in the service of that tenet;
- feeling successful and recognizing that one is on the right path;
- establishing and maintaining a climate in which the intangible elements of collaboration are valued and nurtured;
- support from the larger environment (state and regional systems); and
- an appreciation of the importance of time.

"The leaders in the agencies set the mood for the rest. Sticking together at that level sent a message ... up and down the system. Agency directors and supervisors started trusting each other and they set the environment for the others."

— Linda North, district manager, Vermont Department of Health

Obviously, these elements cannot be transferred wholesale to other communities as if they were ingredients in a cookbook recipe. Every community faces different challenges and possesses different strengths, so every community's list of ingredients is going to combine somewhat differently. On the other hand, knowing and appreciating the ingredients of change in Lamoille give insight into elements that are likely to facilitate successful collaboration in other regions.

Community Partnerships in Lamoille and the PATCH Approach

The earliest community partnership in Vermont was in Morrisville in Lamoille County, a community of less than 10,000 people. Average annual wages in Morrisville were 23 percent lower than the state average.

A strong spirit of collaboration among community support and service providers and families prevails in Morristown. Local health care providers, the local parent-child center (the Lamoille Family Center), Head Start, local schools and other team members are working together in the areas of prevention, health care and education.

The Morristown Elementary School nurse contacts the families of all newborn babies in the Morristown/Elmore area. A home visitor and nurse provide baby visits for those families who request them. Morristown Elementary School, Essential Early Education, Lamoille Family Center and a team of community members

coordinate two screenings of children, at age three and at age five. Organizations also collaborate on several events each year, focusing on education, health care, parent training and literacy, and involving children, their families, support and service providers and other community members.

To ensure that effective collaboration is sustained over time, 15 agencies have become partners. Their commitment to collaboration ensures that families receive the support they need to help their children be ready for school. In these partnerships, agencies agree to:

- work together to develop resources, supports and services;
- use a common process for intake and referrals;
- use common procedures for releasing and sharing information;
- designate a specific case manager in shared cases;
- engage in collaborative problem solving; and
- pool data to evaluate efforts.

Leadership for collaboration in Morristown started at the top with the superintendent of schools, who meets regularly with the district directors of Mental Health and Social and Rehabilitative Services. No one hesitates to call a colleague about a problem, and when problems arise the response is to seek solutions, not levy blame. Serving the needs of children is the driving force behind this cooperation.

Health systems merge

The integration of the health and social services systems has been particularly effective in Lamoille and has resulted in new partnership experiments. These include a merger — between the local health system, Copley Health Systems, and the Lamoille Valley Mental Health and Mental Retardation program — and the development of a long-term care continuum partnership. Lamoille is the first region in the state of Vermont to undertake these kinds of mergers, and Lamoille's work is paving the way for a new statewide model of integrated systems.

Lamoille County Mental Health Services and Copley Health Systems merged in 1994. One of the goals was to create the capacity, through the mental health organization, to bring behavioral health services into the region's five high schools, four middle schools and eight elementary schools. Lamoille County Mental Health, as part of Copley Health Systems, now has individual contracts with every school.[30]

The Lamoille Valley Long-Term Care Partnership got its start in 1995, when Greensboro Nursing Home, Copley Health Systems and the state government began three-way discussions around the concept of constructing a continuum of services for the elderly. In 1996, the state legislature passed a bill that created alternatives to nursing homes in order to both lower long-term cost curves and provide more noninstitutional opportunities for the elderly.

The Casey Foundation facilitated the building of a long-term care team by bringing together leaders from People in Partnership, the Copley Systems and other stakeholders, including the Council on Aging, nursing homes, assisted-living programs, Home Health, Meals on Wheels, elder day care, independent living and Copley Hospital.

The Hardwick PATCH

Late in the Lamoille Valley developmental process, it came to light that the communities of Hardwick, Craftsbury, Craftsbury Center, Greensboro, Stannard and Woodbury were not being adequately served, either by the adjoining human services district in Morrisville or by the district in St. Johnsbury to the east. The area that includes the six towns — which became known as the "Hardwick PATCH" — shows many outcomes worse than Lamoille County's as a whole. Indicators like low birthweight, child poverty, child abuse and neglect, and new families at risk are all significantly worse in this part of the state. Under the PATCH approach, eight different agencies, programs and organizations came together as a single presence in the town of Hardwick.

The Vermont AHS made some adjustments in administrative boundaries to make it easier for these groups to work together.

From a health care point of view, some interesting consolidations and arrangements have taken place in the Hardwick PATCH. Health care in the PATCH area is provided mostly by the Hardwick Area Health Center, whose physicians are credentialed at Copley Health Systems.

The Hardwick PATCH recently has received funding to further develop its partnership, but it is too early in the process to track results in a systematic way. Once the system has been functioning for more than four years (in 2001), we can assess whether or not outcomes and indicators are changing.

Significant Events in Lamoille Valley

Following is an abridged chronology of Lamoille County's partnership initiative.

1992

- Partnership between the state and Copley Health Systems focuses on prenatal care. This effort included the maternal and child health coalition, more local Department of Health emphasis, and the integration of the family and infant-toddlers program.
- Copley Hospital receives a rural transition grant aimed at reducing teen pregnancy. The grant was turned into a community partnership across all agencies and school districts.
- Success by Six first funded.
- Local interagency teams representing AHS, the education community and family-centered projects formally partner.

1993

- Healthy Babies prenatal program begins.
- Several key members of Lamoille Valley's emerging partnership participate in a Danforth Foundation-sponsored "team-building" exercise in St. Louis.

1994

- ❖ People in Partnership is formed.
- ❖ MAPS (Magill Action Planning System) technology is introduced. MAPS training aims to bring families to the center of the case-planning process. Virtually all key players in Lamoille have since received training, including clergy and staff from schools, parent-child centers, the Department of Employment and Training, AHS line agencies (with the exception of Corrections) and others. The work and training products connected to MAPS are representative of a wide variety of Lamoille work products used across Vermont. The Lamoille leaders have spent considerable time in consultation and training with other partnerships.
- ❖ People in Partnership receives state-level Family Preservation/Access funds to help them better meet the needs of families.
- ❖ Lamoille begins focusing on computer technology, including developing online relationships among all partners, access to the state's "Vermont ServiceNet" — an easy-to-use directory of 2,500 services — and experiments with single-application technology.

1995

- ❖ Lamoille County Mental Health and Copley Health Systems formally merge.
- ❖ The multiple-provider team concept expands. This approach pushes health care management for children, families and schools down to the local level. This "site-based" personal planning also uses the MAPS process.

1996

- ❖ A long-term care team is established.
- ❖ The Hardwick area PATCH is established, where eight public, private and school agencies band together, outside of but contiguous to Lamoille County.

- Multidiscipline professional development geared toward common ground and shared results among partners is established.

1997

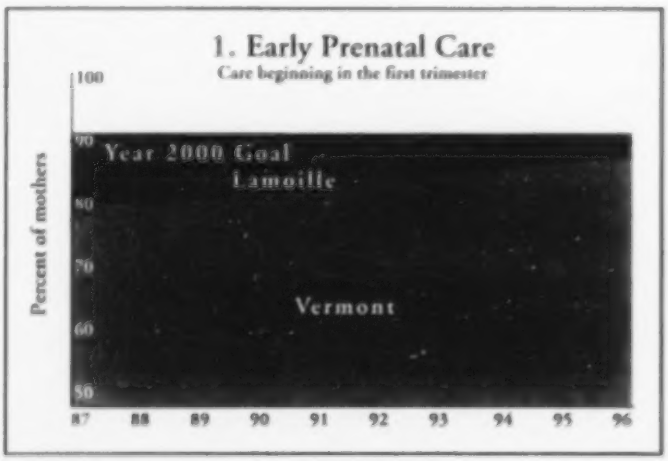
- The start of a rural domestic violence prevention project brings SRS and the domestic violence shelters into closer alignment. For example, domestic violence specialists are now on-site with SRS workers.
- Agreements are negotiated with the state to retain half the savings realized when children are served in their home communities. This process was facilitated by Jolie Bain Pillsbury, Sherbrooke Consulting.

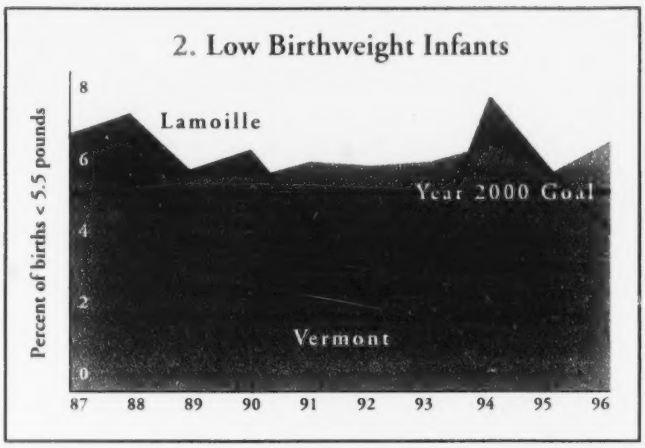
Lamoille County Indicator Trends

Lamoille County has seen improvement in a variety of indicators, illustrated by the following comparison between Lamoille County results and Vermont-wide results. This collection of positive trends demonstrates the strongest progress over the most recent years, and it generally corresponds to the development of Lamoille's partnerships.

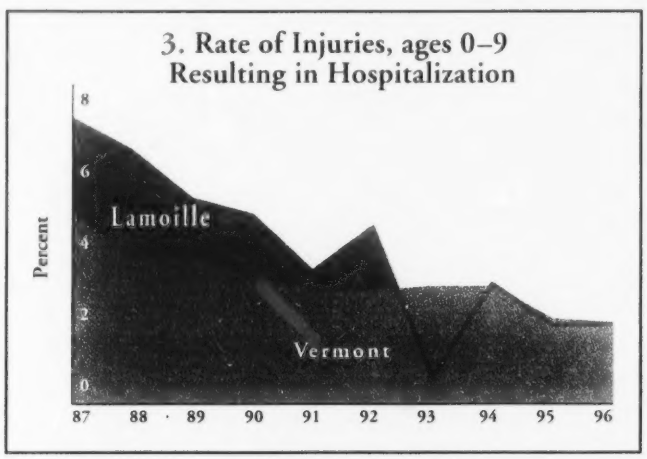
Infants and children

Lamoille County has experienced steadily improving prenatal care. Overall, there is a 10 percent improvement since 1986, very close to the Department of Health's Healthy Vermont 2000 goal.

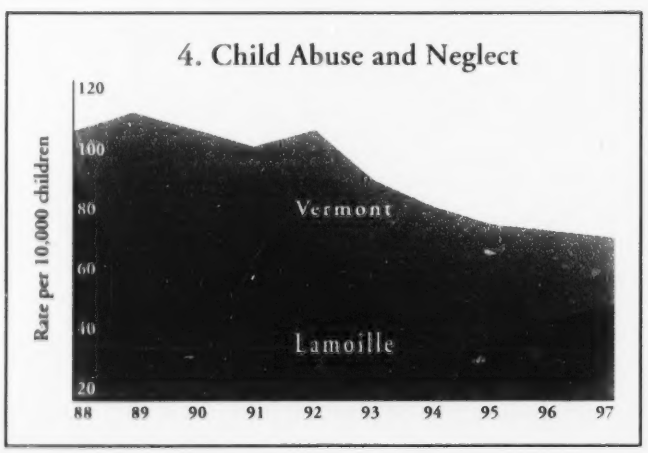




Lamoille Valley's low birthweight rates also track with overall statewide results. Rates have remained stable, just above the Healthy Vermont 2000 goal of five low birthweights per 100 births.



The county has seen a solid drop at a rate faster than that of the state in injuries resulting in hospitalization for children nine years old and under. This indicator has declined a rather remarkable 71 percent since 1987.

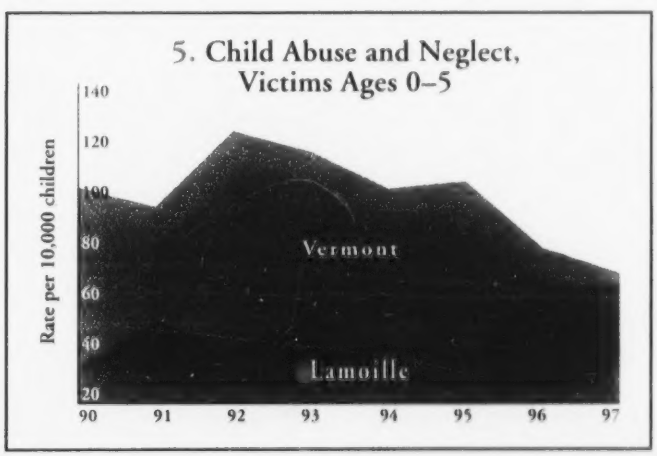


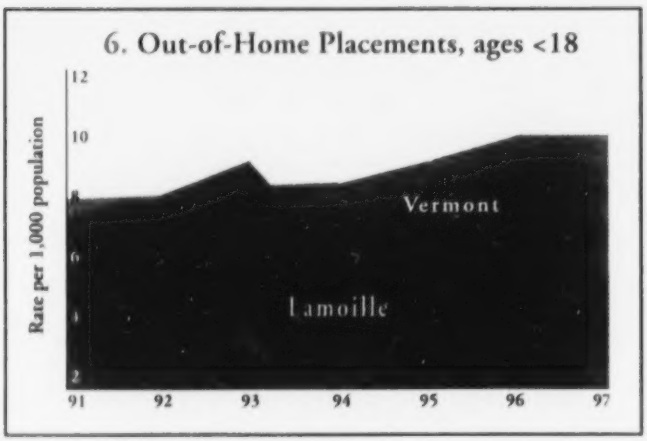
One of the most important achievements has been a reduction of substantiated child abuse and neglect by 48 percent since 1987. This greatly exceeds the overall state reduction of 35 percent over the same period.

Family Preservation funding has been an important asset for improving child well-being in many Vermont communities. One result has been that since January 1998, Lamoille has seen a 15 percent drop in children in AHS custody. Lamoille County Mental Health and Copley Health Systems revised their emergency services so that night calls triggered a series of emergency visits to troubled homes. The aim was to "settle down" difficult family situations. This brief settling-down period helped service providers and families buy time for making better long-term decisions. Family Preservation funds supported this process.

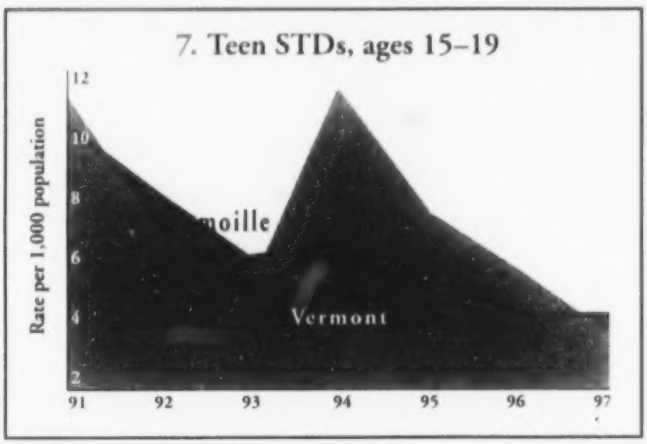
Lamoille has always focused on reducing child abuse. In 1992, the rate of abuse and neglect for children under age six in Lamoille County was only 27 percent of the statewide average. Over the intervening years, state rates have declined by 30 percent, while Lamoille County's rates have remained essentially the same. The state rates have in effect almost caught up with the Lamoille Valley rates.

This speaks to the early work that Lamoille County did in early childhood development, including developing its parent-child center and early prenatal care and other health initiatives. For example, Copley Hospital and SRS have developed special protocols. When a child comes into the emergency room at Copley and there is a suspicion of abuse, hospital staff notify SRS case workers. The sheriff's department used to answer the child abuse hotline, but now the hospital does. Thanks to this shift in emphasis, more people are willing to report child abuse.



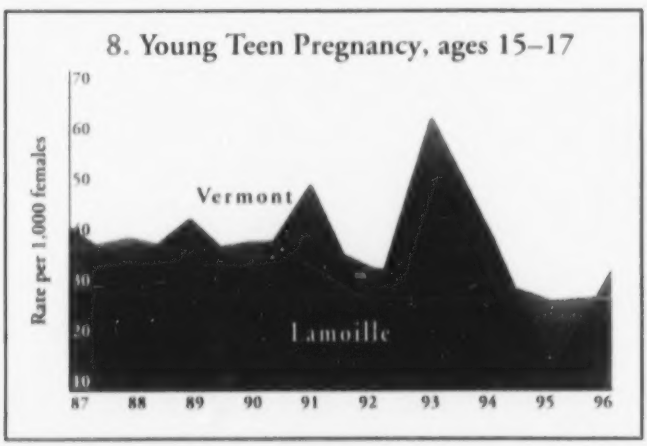


Since 1993, the rate of out-of-home placements for youths under 18 has dropped by 42 percent, during a period when the state rate rose by 30 percent. In this case, we've not only seen Lamoille Valley doing a better job when compared to the state — the data's sharp divergence actually lends credence to the partnership effort.



Teenagers

Since 1991, there has been more than a 40 percent drop in the rate of sexually transmitted diseases among teens in Lamoille County. This performance parallels that of the state of Vermont during the same period.



Even though the numbers are relatively small, resulting in a "popping around" on the graph, Lamoille's pregnancy rate for girls aged 15–17 has declined by 63 percent in the past few years. Over the same period, the state of Vermont has seen a decline of approximately 33 percent.

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Health care

Lamoille Valley also has seen rates of injuries resulting in hospitalization for people aged 18–24 drop by about two-thirds since 1986. This compares to a reduction of approximately 40 percent for Vermont as a whole.

A more recent trend is a strong decrease in nursing facility occupancy as a result of coordinated efforts around long-term care in Lamoille County. Since September 1995, the county has seen occupancy decline from 97 percent to 86 percent. The state has seen a gentle decline in occupancy over the same period, but the rate of change in Lamoille County is about two times the rate of the state.

Fewer Lamoille citizens are entering nursing facilities; instead they are taking advantage of community-based services available for those who require lighter care. Between 1994 and 1997, the state saw lighter-care nursing facility admissions as a percent of total admissions drop from 9.1 percent to 4.2 percent. During the same period in Lamoille, there was a decrease from 18 percent to 4.8 percent. This work corresponds nicely with the emergence of Lamoille's long-term care team.

Scott Johnson
People in Partnership
PO Box 929
Morrisville, VT 05661

Dear Scott and Members of People in Partnership:

It is really amazing to watch the work that you've done together over the past few years. Early on, the Agency of Human Services and the Department of Education felt that partnering with you would teach us a lot about the way things could be done in other parts of the state. It has been a pleasure to see that relationship fulfilled with positive outcomes, to see how much you've affected community partnerships in the state, to see the ways that you've integrated both the long-term care world and the early childhood world with your overall partnership and, finally, to see the degree to which you have helped to develop the PATCH concept in the state.

There is considerable good news in your area as shown by the most recent *Community Profile*. In Lamoille County, access to early prenatal care has gently improved, as have the rates of injuries resulting in hospitalization for all ages.

One of the most striking successes is the reduction in child abuse and neglect, a full 53 percent since 1987, with an acceleration of that decline in 1992.

Your county has also seen a terrific reduction in the teen sexually transmitted disease rate, totaling 42 percent since 1991.

The most striking accomplishment is the phenomenal reduction in your young teen pregnancy rate between ages 15 and 17. That rate in Lamoille County declined a startling 63 percent since 1986, with most of the decline occurring after 1991.

However, we have not seen that progress in the Lamoille South Supervisory Union itself.

As I went through the report, I also noticed some problem areas, most of which are related to young people's risk taking.

That aside, your part of the state should feel a great sense of accomplishment as you are clearly, through your partnership work, making a real difference on behalf of the people that you serve.

Sincerely,

Cornelius Hogan

Cornelius D. Hogan
Secretary
Vermont Agency of Human Services

Avoided Costs for Lamoille County

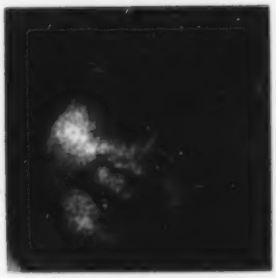
In addition to the human benefits of improved well-being, better outcomes save money by avoiding the costs of services after people have encountered difficulties. To illustrate, we've outlined three Lamoille indicators that have improved and calculated dollars that Lamoille has not had to spend as a result.

Injuries resulting in hospitalization (ages 0–9): During the period 1992–1995, Lamoille children suffered 10 fewer such injuries than they would have if the 1991 number had remained constant. We estimate that each hospitalization represents $13,000, so the total avoided costs over this period were $130,000.

Child abuse/neglect (all ages, all types): From 1992 to 1996, there were 48 fewer victims than if 1991 numbers had remained constant. We estimate that each case costs the county $30,000; total savings over the period were $1.5 million.

Young teen pregnancy: Over the period 1992–1996, Lamoille teens between ages 15 and 17 had 18 fewer pregnancies than 1991 numbers indicated. Since each pregnancy represents about $20,000, Lamoille avoided spending $360,000 during this period.

Endnotes



1. *Statistical Abstract of the United States, Table 44:* "Urban and rural population, 1960 to 1990, and by state, 1990," U.S. Bureau of the Census (Washington, D.C.: U.S. Department of Commerce, 1997).
2. *Application for funding submitted to the Telecommunications and Information Infrastructure Assistance Program (U.S. Department of Commerce)* (Burlington, Vt.: Vermont Telecommunications Application Center, 1998).
3. Ibid.
4. Adele White-Scaccia, ed. *Community Development: Critical Elements in the Lamoille Valley Experience* (Waterbury, Vt.: Vermont Agency of Human Services, Planning Division, undated).
5. *The Social Well-being of Vermonters, 1998: A Report on Outcomes for Vermont's Citizens,* (Waterbury, Vt.: Vermont Agency of Human Services, Planning Division, 1998).
6. *Champlain Initiative: Creating healthy communities* (Burlington, Vt.: Champlain Initiative, 1997).
7. "Managing by Outcomes Changes Everything," *Georgia Academy Journal* (Fall 1997).
8. D. Osborne and T. Gaebler. *Reinventing government: How the entrepreneurial spirit is transforming the public sector* (Reading, Mass.: Addison-Wesley Publishing Co., 1992).
9. C.D. Hogan. *The human services response to preventing sexual offending.* Remarks to the Association for the Treatment of Sexual Abuse. (Waterbury, Vt.: October 1997).
10. Between 1991 and 1996, the birth rate for teens in Vermont (births per 1,000 girls aged 15–19) fell from 39 to 30 (a 23 percent decline), according to *The Social Well-being of Vermonters, 1998: A Report on Outcomes for Vermont's Citizens* (Waterbury, Vt.: Vermont Agency of Human Services, Planning Division, 1998).
11. For the period 1990–1995, Switzerland had a rate of five births per 1,000 girls aged 15–19, according to UNICEF *(The Progress of Nations,* 1996). In 1993, Vermont's rate was 35, according to *The Social Well-being of Vermonters, 1998: A Report on Outcomes for Vermont's Citizens* (Waterbury, Vt.: Vermont Agency of Human Services, Planning Division, 1998).

12. Estimated annual cost of child abuse and neglect in Vermont (including medical care, mental health care, future earnings and public programs) is $25,562,000 (1993 dollars). However, Miller et al. use a figure of $4,883,000 for "public programs," or $2,929,000 ($3,087 in 1995 dollars) per reported victim in 1993 (N = 1667); our own SRS estimates are that residential costs alone average $17,000 per year. If we use this latter figure for the estimate of "public programs," then the total cost is $49,018,000 (1993 dollars), or $29,405 per victim ($30,992 in 1995 dollars). Source: Children's Safety Network Economics and Insurance Resource Center at the National Public Services Research Institute (Landover, Md.: 1994). Costs per case from T.R. Miller, M.A. Cohen and B. Wiersma, *Crime in the United States: Victim costs and consequences,* Research in Brief, National Institute of Justice Grant #90-IJ-CX-0050, 1994.

    For the period 1991–1995, there were a total of 1,031 fewer abuse/neglect victims than there would have been had abuse/neglect remained at the 1990 level. 1,031 x $31,000 = $31.9 million. (Data from Vermont Department of Social and Rehabilitative Services.)

13. M. Gladwell. "The Tipping Point," *The New Yorker,* June 3, 1996, pp. 32–38.

14. D. Both and C. Marzke. *A Vermont Case Study on System Reform.* The National Center for Services Integration, 1995.

15. The State Team was established in May 1994 to foster greater collaboration among agencies, organizations, existing interagency teams and community members working with children and their families. Current membership includes the division directors of state agencies serving children, families and individuals; state-level coordinators of interagency teams; directors of several major family service and advocacy organizations; and representatives of the State's 12 regional partnerships.

16. *The Social Well-being of Vermonters, 1998: A Report on Outcomes for Vermont's Citizens,* op. cit.

17. C.D. Hogan. *FY 99 Budget & Program Overview and Recommendations for the Agency of Human Services* (Waterbury, Vt.: 1998), p. 62.

18. Legislature of the State of Vermont, S. 294: *An act relating to state and community partnerships,* introduced in the 1998 session. Montpelier, Vt.

19. A complete listing of the Vermont outcomes and indicators as of March 1, 1998.

20. *The Social Well-being of Vermonters, 1998: A Report on Outcomes for Vermont's Citizens,* op. cit.

21. For example: A. Lisberg. "Teen drinking called 'an epidemic,'" *Burlington Free Press,* March 24, 1998.

22. *Community Profiles* (Waterbury, Vt.: Vermont Agency of Human Services, Planning Division, 1997). Internet address: www.dsw.state.vt.us/ahs.
23. *Healthy Vermonters 2000* (Burlington, Vt.: Vermont Department of Health, 1993).
24. Personal communication with Cheryl Mitchell, deputy secretary, Vermont Agency of Human Services, March 1998. Estimate is based on annual number of births and a proportion of those visited, which increased from approximately 10 percent in 1992 to approximately 70 percent in 1997.
25. *The Social Well-being of Vermonters, 1998: A Report on Outcomes for Vermont's Citizens*, op. cit.
26. For example, between 1991 and 1996, rates of child abuse (all types) fell 27 percent in Vermont (from 99.1 per 10,000 to 72.6). In Lamoille County, even starting from a much more favorable position, rates fell 33 percent over the same period (from 67.2 to 44.8). *Community Profiles* (Waterbury, Vt.: Vermont Agency of Human Services, Planning Division, 1997).
27. M. Friedman. *A guide to developing and using performance measures in results-based budgeting* (The Finance Project. Washington, D.C.: 1997).
28. *Community Development: Critical Elements in the Lamoille Valley Experience*, op. cit.
29. Interview with William Alexander, executive director of Lamoille County Mental Health Agency, March 30, 1998.
30. Interview with Carolyn Roberts, CEO of Copley Health Systems, March 30, 1998.

Afterword

By Mark Friedman

Tapping Into Leadership

Vermont is among the leading states working on cross-agency, cross-community results for children and families, and the state's accomplishments give us some insight into what it takes to make this kind of change take hold.

The single most important ingredient is leadership. Without strong leadership, nothing much happens. It takes leaders who are committed to working together, who can set aside the pressure to compete with one another and find common ground in working to improve the well-being of children, families and communities. Vermont has a wealth of leadership at both the state and local level.

The most important way in which leaders create change is by setting an example. In Vermont, Con Hogan, secretary of the Agency of Human Services, has set an example of how to think about results, communicate with a wide range of audiences, be a real — and not an in-name-only — partner and move from talk to action on child and family well-being. At the local level in Vermont, there are too many people to name who provide this same kind of leadership in their communities. Leadership is the difference between the all-talk version and the change-for-the-better version of results-based accountability.

Closely related to leadership is the recognition that this work is not just a new initiative or program, but a change in culture. Our system of services for children and families has grown over the last 50 years into a highly categorical maze of overlapping services. What gets lost in this maze of "means" are the ends we are trying to accomplish for children, families and communities — ends like children born healthy, ready for school, succeeding in school, and becoming productive and contributing adults. In Vermont, people are changing the way they think about child and family well-being and what it takes to improve conditions. Working together has long been a part of Vermont culture, so that is nothing new. But clearly stating goals from the start and working backward to get there is a shift from the past.

Leaders also must put in place a clear framework for these endeavors that allows partners to complement each other's efforts, not compete with them. Language clarity is a central part of such a framework. Language discipline is not about an official glossary of terms or making everyone use exactly the same words. It's about having a common set of ideas that helps people understand how their work fits into a larger whole. Vermont has such a framework in its development of outcomes and indicators. The ancient image for the alternative is the Tower of Babel, and the ruins of many such towers litter the social history landscape.

Effective leaders also know that this work takes time. In data alone, we are 100 years behind the business community with its up-to-the-second Dow Jones stock averages and 50 years behind the labor movement, which has pretty good monthly unemployment and other labor force statistics. Maybe some day we will have the Bureau of Family and Children's Statistics, the equivalent of the Bureau of Labor Statistics, and each month the press will anxiously await the release of the latest figures on childhood immunization, reading at grade level or teen pregnancy. We have a long way to go to get the data we need, but we can start with what we have, while we work to improve our data resources. Vermont has made some hard choices as well as some great progress with its data.

Finally, leadership in this arena means a determination not to accept excuses. There are a thousand excuses for not being accountable for the well-being of children and families. Everyone can point to someone else. City government can point to county government, county folks can point to the state government and the state agencies can point to the federal government. The school system can point to the juvenile justice system, which can point to the health system. The public sector can blame the private sector. The executive branch can finger the legislative branch — and so forth. Lack of data, as described above, is another excuse, one that Vermont is working hard to overcome.

It seems the concept of results-based accountability has come into its own. By one count this work is taking place at the state or local level in more than half the states. Some of the leaders include Vermont, Georgia, Missouri, California, Oregon and Alaska. Much of the best work is happening at the county and community level in these and other states. And it is an international movement, too, with work in a number of countries (notably the Netherlands, Australia, Canada and South Africa) as well as the United Nations.

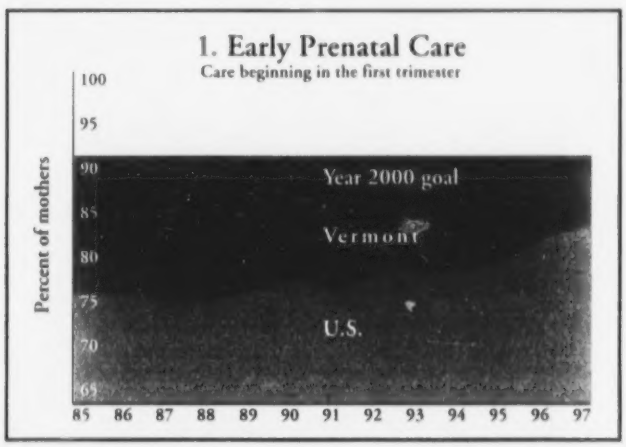
It is important for people to recognize that those who do this work today are not alone. There is a growing body of literature, like this paper, and a growing network of people, like the partners in Vermont, who have a wealth of experience to share about what works to improve the lives of children and families and how to actually carry out results-based accountability. It bodes well for children and families that so many people around the country are bringing their considerable talents to the table. We urge you to get in touch with this network. Tell us what you've been able to do. Help make this a learning community where everyone is both a teacher and a learner. Ultimately, what it takes is everyone with an oar in the water — or a tap in the tree, as the case may be.

Appendix A

Vermont Indicators

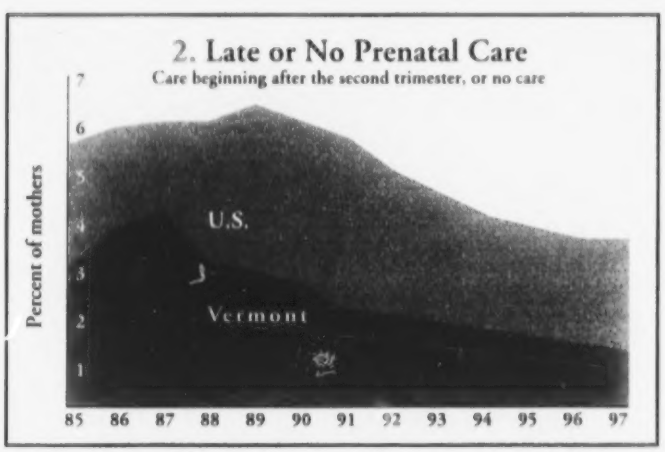
Vermont's annual "well-being report," *The Social Well-being of Vermonters*, is a key strategy in providing information around which state policy-makers and local partnerships can focus to improve indicators of well-being. It is also a valuable tool for making budgetary recommendations, allowing us to address particularly weak areas by investing extra funds or creating new programs.

The following are noteworthy statewide improvements in indicators that represent improved well-being for people in Vermont compared to the nation as a whole.



Nearly nine out of 10 pregnant Vermont women receive early prenatal care.

Early prenatal care for Vermont women has improved by 12 percent since 1987.



About one in 50 pregnant Vermont women receives late or no prenatal care.

Late prenatal care has declined substantially, by 56 percent since 1987.

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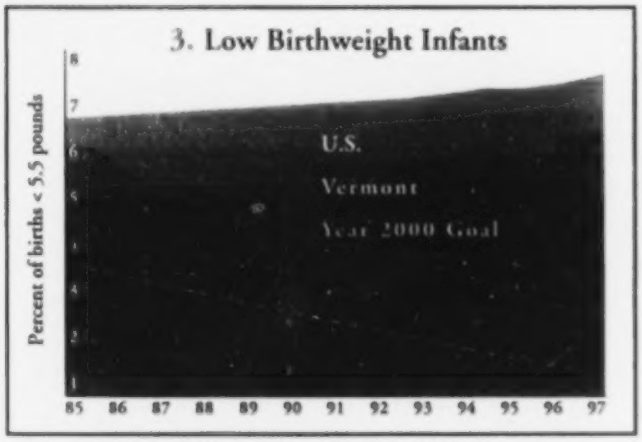
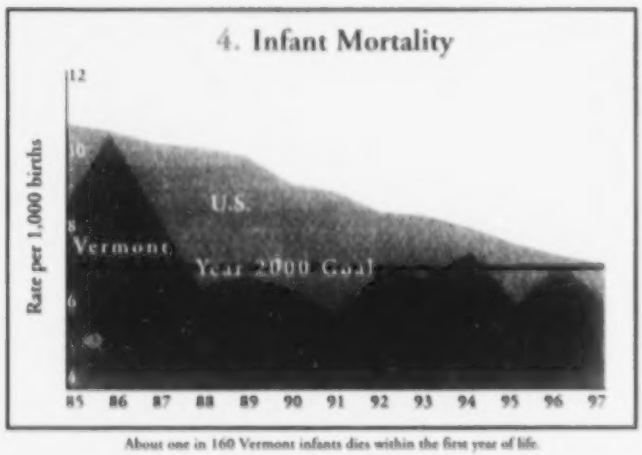


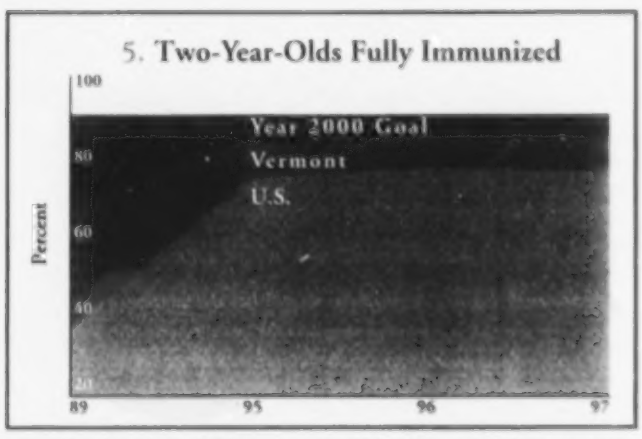
About one in 17 Vermont babies has low birthweight.

The number of infants with low birthweights has gently but perceptibly risen, and although significantly less than U.S. averages, is uncomfortably above the year 2000 goal and 55 percent higher than Norway's rate.



About one in 160 Vermont infants dies within the first year of life.

Infant mortality remains a challenge for Vermont. Although the rate has been steady since 1988, the rest of the nation has caught up with Vermont. The state's regional partnerships, especially in those areas with the highest infant mortality rates, will be working more closely with physical health systems to improve the results.



More than eight out of 10 Vermont two-year-olds have all recommended immunizations.

Vermont's immunization rate is among the best in the nation and continues to improve.

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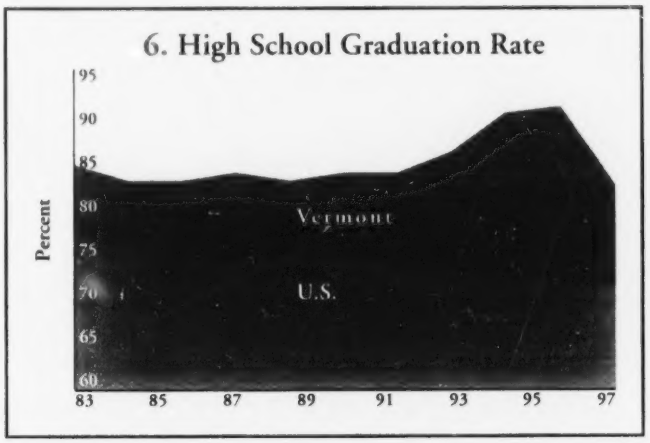
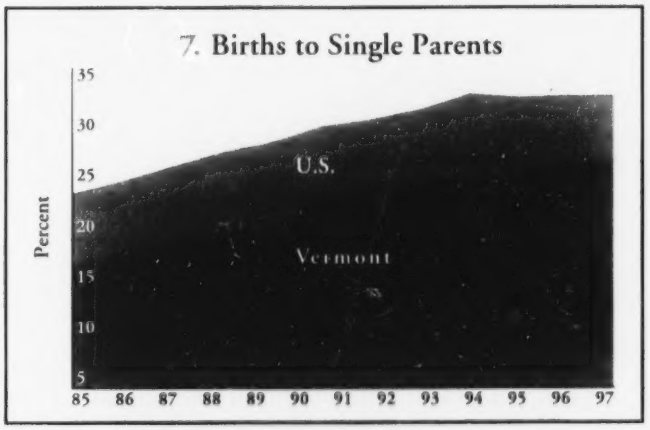
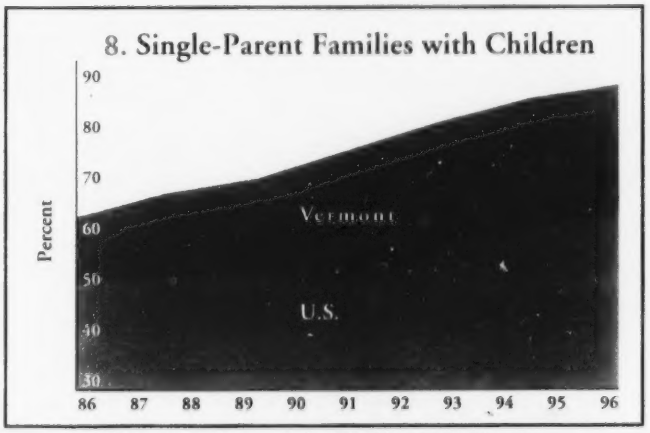


Vermont's high school graduation rate is quickly improving, in contrast to the steadily declining rate for the country as a whole.



About one in four Vermont children is born to a single parent.

Vermonters are particularly concerned about the continuing rise in the rate of births to single parents, which has risen from 17 percent to 26 percent over the last 10 years. Our rate is significantly below that of the nation, but is viewed as a contributing factor to poor economic outcomes for families.



Nearly one in four Vermont families with children is headed by a single parent.

In Vermont, although births to single parents are rising, the number of single-parent families with children is leveling off, which suggests that after a child is born, more Vermont couples are setting up households together.

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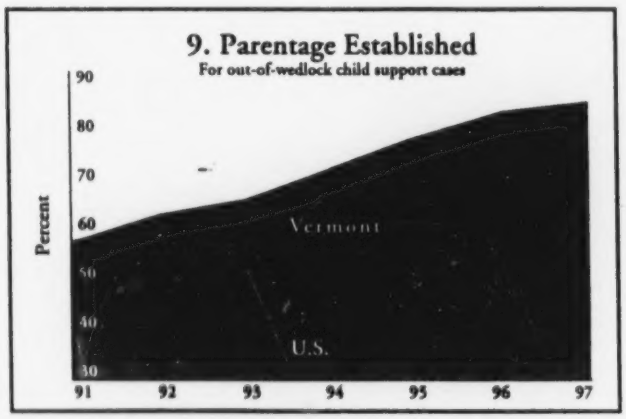
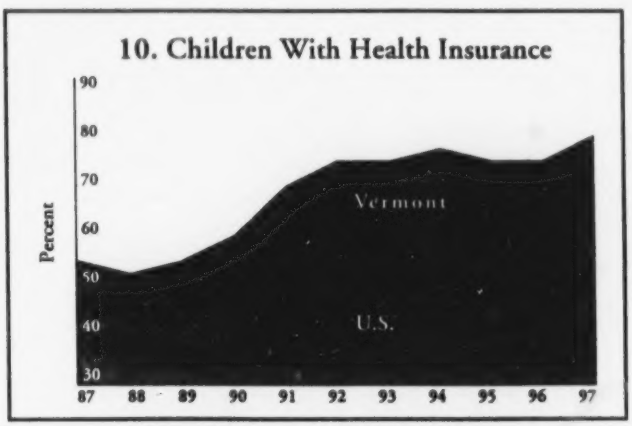


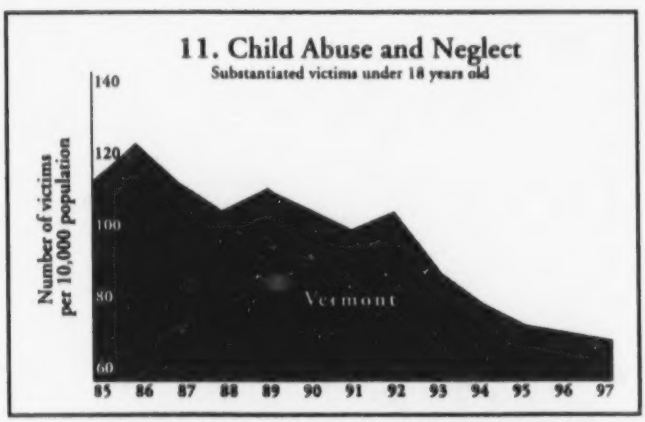
Eight of every 10 Vermont children born out of wedlock have parentage established for purposes of child support.

Vermont has made excellent progress since 1991 in establishing parentage for out-of-wedlock child support cases, improving from 57 percent in 1991 to 84 percent in 1997.



About one in 20 Vermont children is without health insurance.

Nearly all Vermont children now have access to health insurance. Current assessments place us at the 95 percent mark. We plan to increase that achievement by at least another two percentage points.



About one in 140 Vermont children is a victim of substantiated abuse or neglect.

The number of substantiated victims of child abuse and neglect has declined greatly over the last decade, particularly since 1992. Overall, we've seen a 40 percent reduction since 1986, with a 30 percent reduction since 1992.

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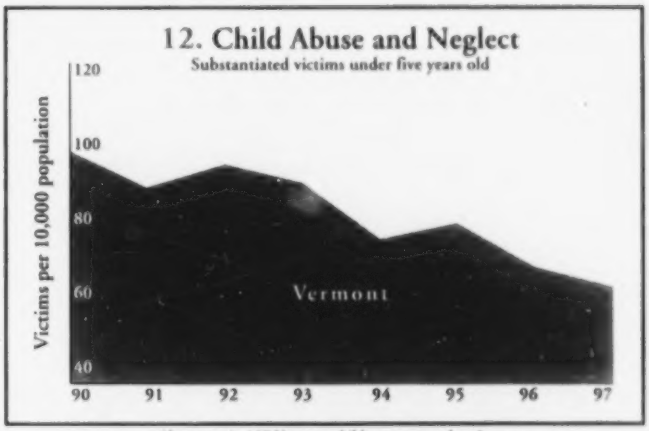
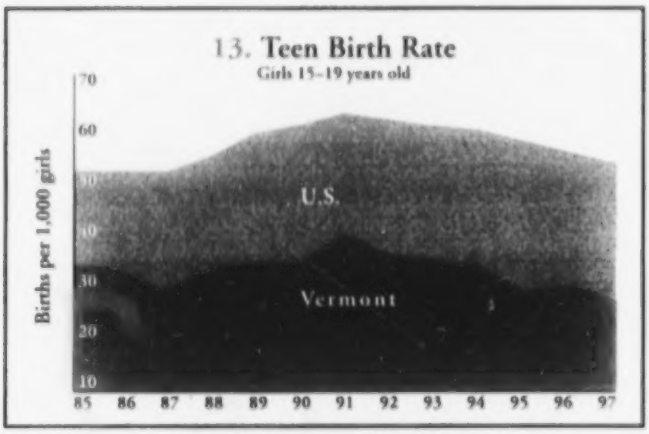


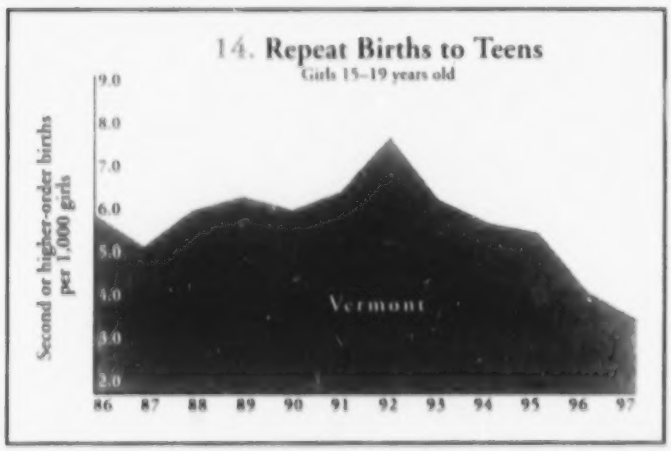
About one in 157 Vermont children younger than 5 years is a victim of substantiated abuse or neglect.

The real news in child abuse declines is occurring in the under-five cohort, where child abuse and neglect has declined by 33 percent since 1992. We believe this is a result of expanded health insurance, more universal early baby visiting and the strength of the community partnerships.



About one in 37 Vermont teen girls gave birth in 1997.

Vermont's rate of births to teenagers has dropped 31 percent since 1991. The state has the lowest teen birth rate in the nation.



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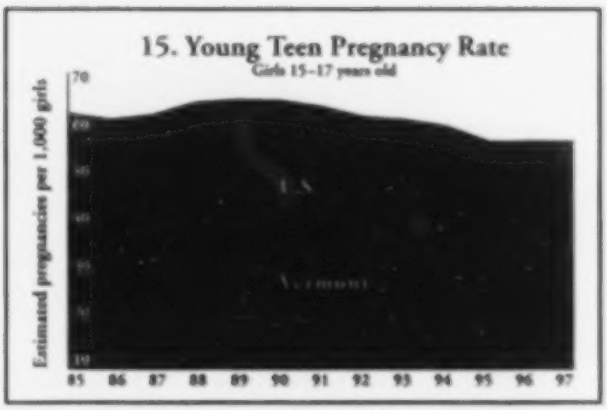
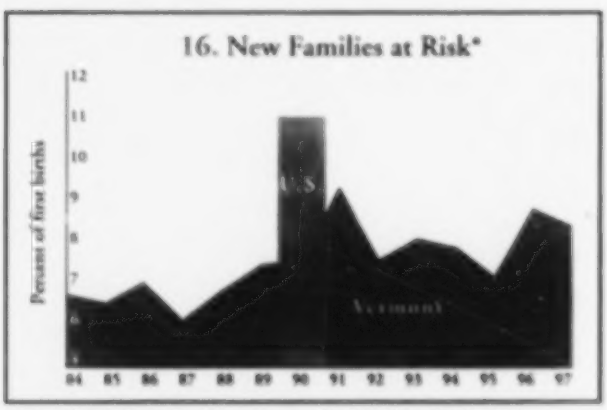

15. Young Teen Pregnancy Rate
Girls 15–17 years old
Estimated pregnancies per 1,000 girls
70
U.S.
Vermont
85 86 87 88 89 90 91 92 93 94 95 96 97

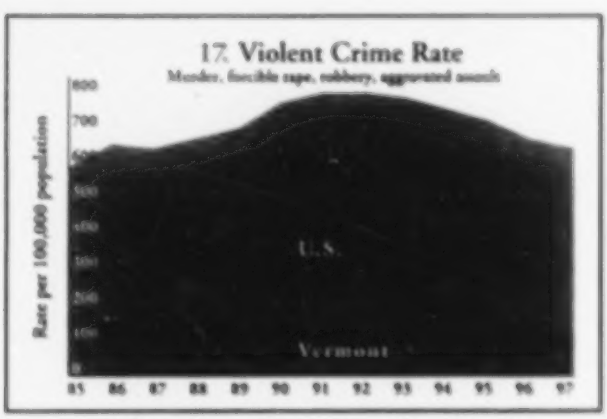
About one in 63 Vermont girls 15–17 years old became pregnant in 1997.

The young teen pregnancy rate (for girls aged 15–17) has declined 40 percent since 1991.



*First births to unmarried women younger than 20, with less than 12 years education.

One particularly important indicator is the rate of new families formed who are at risk of experiencing bad outcomes. We do not have comparable national data for this indicator, but we do track it. The rate has remained steady since 1990.



In Vermont, about one violent crime is reported for every 830 people.

Vermont's rates of violent crimes and homicide (see page 58) are low and steady compared to the rest of the nation.

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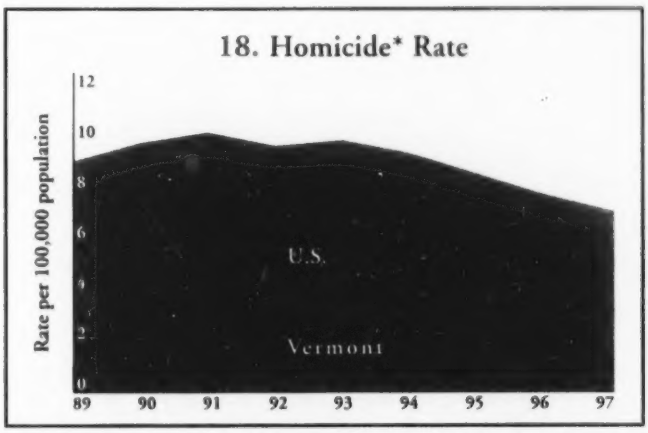
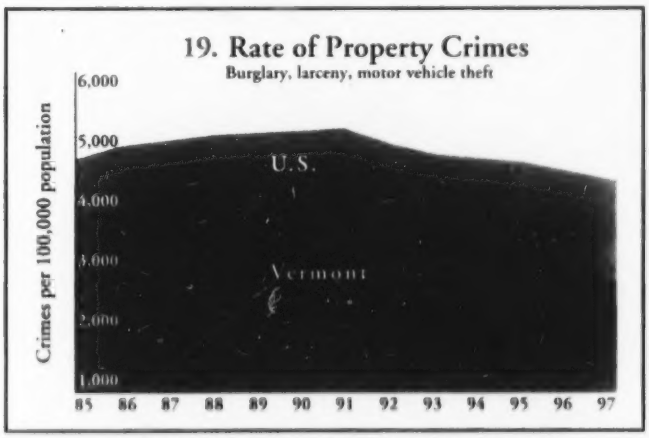
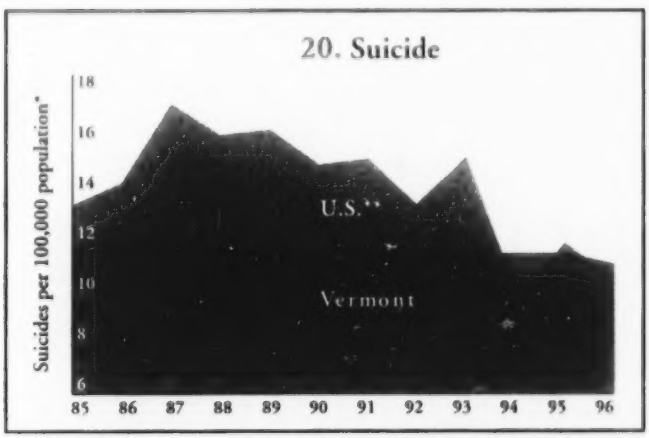


*Includes murder and non-negligent manslaughter; excludes death due to legal intervention.



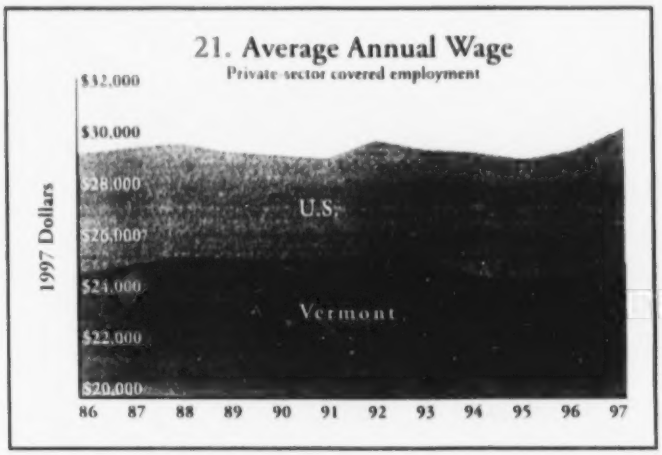
In Vermont, about one property crime is reported for every 37 people.

Vermont has experienced a significant reduction of 32 percent in the rate of property crimes since 1990.



* Rates are age-adjusted to the U.S. 1940 population, to account for the aging of our population over time.
**U.S. 1996 data are preliminary.

The state has seen a steady and long decline of suicides from levels that were well above the national average in 1987 to levels at the national average in 1996. This is an overall rate reduction of 39 percent since 1987.



Vermont's positive trends have occurred in the context of a decline in the average annual wage, which in Vermont is 16 percent below the national average.

National Rankings for Vermont's Children and Youth, 1995

	Previous Year	*Current Year*	*Nat'l. Rank*
High school students who graduate in four years (1994)	79%	89%	1st
Children with health insurance	85%	96%	1st
Girls aged 15–19 not giving birth	96%	97%	1st
Girls aged 15–17 not becoming pregnant	96%	97%	n/a
Out-of-wedlock child support cases with parentage established	42%	84%	2nd
Children not abused or neglected	99%	99%	2nd
Infants born not with low birthweight	94%	94%	3rd
Two-year-olds fully immunized	68%	85%	3rd
First births not to "new families at risk"	91%	91%	3rd
Children not in poverty	86%	87%	4th
Women receiving first trimester prenatal care	78%	87%	7th
Children ready for kindergarten	72%	73%	8th
Children born to married parents	88%	74%	7th
Families with children headed by married parents	79%	78%	7th
Youth (ages 16–19) employed	87%	86%	n/a

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How Indicators Connect to Outcomes in Vermont

1. Outcome: Pregnant Women and Newborns Thrive

Indicators:

- Percent early prenatal care
- Percent low birthweight

2. Outcome: Infants and Children Thrive

Indicators:

- Infant mortality rate
- Rate of injuries (ages 0–9) resulting in hospitalization
- Child mortality rate

3. Outcome: Children Are Ready for School

Indicators:

- Percent of kindergartners fully immunized
- Percent of children ready for kindergarten

4. Outcome: Children Succeed in School

Indicators:

- School attendance rate
- New Standards English/Language Arts assessment scores
- Arts assessment scores
- New Standards Math assessment scores
- Percent of students with special education IEPs
- Scholastic Assessment Test scores
- Percent high school dropouts

5. Outcome: Children Live in Stable, Supported Families

Indicators:

- Percent children in poverty, 1989
- Percent children in families receiving Food Stamps (proxy for children in poverty)
- Percent child support paid
- Rate of child abuse and neglect
- Rate of out-of-home placements (ages < 18 years)
- Average number of moves within the child substitute care system

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6. Outcome: Youth Choose Healthy Behaviors

Indicators:

- Percent of students smoking cigarettes within the last 30 days
- Percent of students using alcohol within the last 30 days
- Percent of students using marijuana within the last 30 days
- Rate of teen sexually transmitted diseases
- Rate of young teen pregnancy (ages 15–17)
- Rate of injuries (ages 10–17) resulting in hospitalization
- Rate of custody for children deemed "unmanageable"
- Rate of court dispositions for delinquency
- Rate of delinquents in custody
- Rate of teen violent deaths

7. Outcome: Youth Make a Successful Transition to Adulthood

Indicators:

- Percent of high school seniors with plans for education, vocational training or employment
- Rate of new families at risk
- Rate of out-of-home placements (ages 18–24)
- Rate of injuries (ages 18–24) resulting in hospitalization
- Rate of teen nonviolent deaths

8. Outcome: Families and Individuals Live in Safe and Supportive Communities

Indicators:

- Rate of injuries (ages 25–64) resulting in hospitalization
- Rate of injuries (ages 65 +) resulting in hospitalization
- Rate of out-of-home placements (ages 25 +)
- Percent of adults who smoke
- Percent of adults who are "binge drinkers"
- Rate of petitions filed for relief from domestic abuse
- Rate of adult abuse and neglect reports
- Rate of suicide (ages 18 +)
- Rate of violent crime
- Percent of people above poverty level
- Average median household income
- Average annual wage
- Rate of job creation
- Percent living in affordable housing
- Percent of affordable housing
- Percent met need for child care

Appendix B

Barre — Pulling Together for Results

The City of Barre organized its community partnership around a handful of fundamental objectives, mainly reducing teen pregnancies and child abuse by using life-long literacy and learning as a vehicle. In early 1997, when Vermont's Agency of Human Services published local *Community Profiles* for the second year, we pointed out that Barre's teen pregnancy rates, child abuse rates and family risk-formation rates were extraordinarily high.[1]

This was data thoughtful people could not ignore. Shortly after, a newspaper article described a city council debate on the issue of teen pregnancy. Out of that flowed some modest foundation support and a process to engage the community's leaders, including the mayor's office and school board, in improving outcomes for Barre's young people. Barre has adopted the theme "Lifelong Learning and Literacy" as a framework for changing trends in the data. Following is an excerpt from Mayor Paul Dupre's 1998 "State of the City" address that captures the vitality of the Barre work.[2]

> It is not just our buildings and stores that need our attention. We need to pay attention to the social needs of our community. A little over a year ago, Barre City received a *Community Profile* from the State of Vermont. This profile indicated some disturbing trends. We have a high percentage of families at risk. Our teen pregnancy rate is high, substance abuse rate is high and abuse rates in our families are high.
>
> Again, we chose to take option two and instead of throwing up our hands, we asked ourselves how we could meet this challenge to the social fabric of our community.
>
> The State of Vermont Secretary of Human Services and the Commissioner of Education offered Barre City an opportunity through a grant initiative from the Danforth Foundation to meet this challenge. A group that calls itself the Danforth group or committee was formed to present a consolidated effort by education, human services and government to address these trends shown on the *Profile*.
>
> This group began meeting over a year ago and through support and money from the Danforth Foundation began to develop a strategic plan. Many televised meetings were held throughout the year, including a four-day retreat in Burlington. A theme for Barre City emerged — "Barre: Learning For Life." This led to the community forum at Spaulding High School in December. About 50

people attended that forum to discuss three specific topics related to the community profile. These topics were: literacy, community values and substance abuse. Hundreds and hundreds of practicai ideas were generated on ways that we as a community could address these issues in Barre.

All of this has now led to the formalization of a steering committee, called the Danforth committee. This committee will be led by Steve Mackenzie, the city school board chairman and myself. The committee is made up of Barre citizens, teachers, human service workers and other interested parties. It will meet once a month until the subcommittees get started and then will meet quarterly.

The Danforth committee received a $17,500 grant from the Danforth Foundation and will use that to assist the subcommittees with some of their expenses. $10,000 of this grant must be used for research. We will use the yearly *Community Profile* as our main way of knowing if we are achieving our goals.

We have hired a part-time coordinator who will assist all of the volunteers on each of the subcommittees to organize their efforts towards achieving their goals. This initiative will only be successful if all of us take an active role. While we will receive some money, it is really you and me, as citizens of Barre, who will make the difference.

The subcommittee on substance abuse is in the process of applying for some of the money the state received this year. That will go a long way towards prevention, education and other means of trying to get the message out that drugs are not the answer to dealing with emotional or physical pain. However, we will never address the real questions by just trying to put the drug dealers out of business. We must answer the question as to why our young people or ourselves need to numb our minds. Why is it that so many do not see the challenge of each day and the wonder of the human mind to meet that challenge?

The subcommittee on common values may help with some answers to these questions. Who are we? What do we believe in? What is important to us? Why do we get up each morning and put one foot in front of the other?

How can we make our values real and live them out in a way that our children will want to imitate us? Our children do imitate us, whether we like it or not. It is important for us to be conscious of this and decide what type of teachers we want to be to them.

Barre's literacy subcommittee will be working on all aspects of learning. Learning to earn and learning for fun. The city voters just passed a bond for

> $500,000 to increase the size and capacity of our library. I see this as a positive sign that reading and learning are of central importance to our community. I think this theme in itself captures all three.
>
> Just as we need to build our buildings on a strong foundation, we need to build a strong foundation of learning for our children to grow up on. We need to spend time with our children. Read to them and with them. We need to be there when they need us to answer their questions about life.
>
> How are we going to do all of this? The only way we will be successful is if we put the emphasis on "we." This is not a one- or two-person job. It is all of our responsibility to make these initiatives work for our children and our community.
>
> If we want a drug-free community, if we want a community that lives its values in a way that will challenge our youth to do likewise, if we want our children to be literate about what it takes to live a healthy, full life, then we, the citizens of Barre, will have to step forward and volunteer some of our time each week to make it happen.
>
> There are nearly 10,000 people in the city of Barre. If each of us volunteered an hour of our time each week we would have no difficulty meeting these needs.

Barre represents a new, healthy form of accountability, based on the common desire of many people for the same results. It is an accountability that also allows for sharing credit. It is not based on programmatic success or failure or negative processes that ultimately lead to the blame game. Barre's style of accountability includes many players, in and out of government and the formal health, education and human services systems, who can participate in and contribute to visible, significant changes in well-being. In this context, accountability is less consumed with local structure than it is with local results.

Endnotes

1. *Community Profiles* for Barre City School District (Waterbury, Vt.: Vermont Agency of Human Services, Planning Division, 1997).
2. Mayor's address to the City of Barre, March 10, 1998.

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